STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0023	A. BUILDING: ______ B. WING ______	C 09/16/2021

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BRIDGEPOINT SUBACUTE AND REHAB NATIONAL H	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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L 000	Initial Comments An unannounced Annual survey was conducted at Bridge Point National Harbor on the following dates- August 23, 2021 - September 16, 2021. The survey team conducted the recertification survey onsite at the facility on August 23 - 26, and 30, 2021 and September 3, 8 and 15, 2021. Survey activities consisted of a review of 44 sampled residents. The facility's census during the survey was 122. The following complaints and facility reported incidences were investigated during this survey: DC00010058, DC0001006, DC00010184, DC00010199, DC00010201, DC00010202, DC00010198, DC00010227 and DC00010240. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 22B District of Columbia Municipal Regulations Chapter 32. It should be noted that during the joint State and Federal survey the facility was cited at an immediate jeopardy (IJ) under: 42 CFR§483.12 Freedom from Abuse, Neglect, and Exploitation, F600 on September 8, 2021 at 1:55 PM. The facility's Administrator provided a plan of corrective action to address the identified concerns on September 8, 2021 at 7:32 PM. After the plan was verified the IJ was removed on September 16, 2021 at 7:52 PM. 42 CFR§483.25 Quality of Care- Treatment/Services to Prevent/Heal Pressure Ulcers, F686 on September 8, 2021 at 2:01 PM. The facility's Administrator provided a plan of	L 000	**L 000-Preparation and/or execution of this plan of correction do not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it. This plan is submitted as evidence of our compliance.**	

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L 000	Continued From page 1	L 000		

corrective action to address the identified concerns on September 8, 2021 at 7:31 PM. After the team verified that the plan of correction was in place on September 16, 2021 at 7:52 PM, the IJ was removed.

The following deficiencies are based on observation, record review, and resident and staff interviews.

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
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

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L 000	Continued From page 2 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 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	L 000		

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L 000	Continued From page 3 SCC Special Care Center Sol- Solution TAR - Treatment Administration Record Ug - Microgram	L 000		
L 001	3200.1 Nursing Facilities Each nursing facility shall comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. This Statute is not met as evidenced by: Based on observations, resident and staff interview, and review or facility documents and resident records, facility staff failed to comply with the Act, these rules and the requirements of 42 CFR Part 483, Subpart B, Sections 483.1 to 483.75; Subpart D, Sections 483.150 to 483.158; and Subpart E, section 483.200 to 483.206, all of which shall constitute licensing standards for nursing facilities in the District of Columbia. The facility's census during the survey was 122. The findings include: Immediate Jeopardy (IJ) represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death. These situations must be accurately identified by surveyors, thoroughly investigated, and resolved by the entity as quickly as possible. In addition, noncompliance cited at IJ is the most serious deficiency type, and carries the most serious sanctions for providers, suppliers, or laboratories (entities). An immediate jeopardy	L 001	**L 001** **A. Under 42 CFR §483.12, F600, Freedom fromAbuse, Neglect, and Exploitation** 1. Corrective action for resident Identified resident #105 (no longer resides in the facility) was interviewed 9-8-2021 and signed their statement. The identified Aide was terminated on 9-01-2021. 2. Identify other residents An audit of all other resident's completed. There were no additional findings related to this citation. 3. Systemic changes All FRIs from January 2021 to present were reviewed to ensure that they were properly investigated. Education files of any staff involved in the FRIs were reviewed to ensure that appropriate actions were taken regarding their involvement. Education/Designee will in-service all staff on the Abuse Policy and procedures. New Administrator and Governing Board will in-service leadership on the Abuse Policy and procedures. In the future, any employees involved in allegations of abuse, neglect, exploitation, or mistreatment will receive immediate in-servicing on the facility's Abuse Policies and Procedures. All future FRIs/	09/15/2021

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L 001	Continued From page 4	L 001		

situation is one that is clearly identifiable due to the severity of its harm or likelihood for serious harm and the immediate need for it to be corrected to avoid further or future serious harm.

https://www.cms.gov/Regulations-and-guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf

A. Under 42 CFR §483.12, F600, Freedom from Abuse, Neglect, and Exploitation

Based on a review of clinical records, facility documentation, facility policies, and resident and staff interviews, for one (1) of 44 sampled residents, the facility's staff failed to prevent and protect Resident #105 from psychological and physical abuse by Employee #5 and because of the Employee's employment history, there is a likelihood of the employee abusing other residents.

Due to these failures, an immediate jeopardy situation was identified on September 8, 2021 at 1:55 PM. The facility submitted a plan of action to the survey team that was on onsite at 7:32 PM on September 8, 2021, and the plan was accepted. The survey team returned on September 16, 2021 to validate the facility's plan, and the immediate jeopardy was lifted on September 16, 2021, at 7:52 PM. After removal of the immediacy, the deficient practice remained at a potential for more than minimal harm for all remaining residents at a scope and severity of H.

The findings include:

Review of the facility's policy entitled, "Abuse Investigation and Reporting" with a review date of 08/2020 revealed, "... The administrator will

allegations conclusions will be forwarded by email/writing the LNHA/HR/DON/Departmental Supervisor [Licensed Nursing Home Administrator/Human Resource/Director of Nursing] with the results and preventative measures that have been put in place to protect the resident.

4. Monitor corrective actions

Administrator/ Designee will conduct an audit all FRIs weekly for 2 months to ensure the facility has completed a thorough investigation of the alleged violation; prevented further abuse, neglect, exploitation and mistreatment from occurring while the investigation was in progress; and took appropriate corrective action, as a result of investigation findings. Results of finding will be forward to QAPI for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is September 15, 2021.

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L 001	Continued From page 5 ensure that further potential abuse, neglect exploitation or mistreatment is prevented ..." Review of the facility's policy entitled, "Abuse and Neglect- Clinical Protocol" with a review date of 08/2020 revealed, " ... The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect ..." Facility staff failed to provide a safe environment to prevent and protect Resident #105 from the likelihood of abuse from Employee #5. Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome. On 08/19/2021 a complaint was received by the State Agency that documented, "[Resident #105... reported to the Ombudsman... on the night of August 18th [2021] the nursing Aide stuffed [Resident #105's] brief with pieces from a chuck (incontinence pad) and said 'I am not changing you again tonight' ..." Review of a memo from Employee #1 (Administrator) dated 08/24/2021, documented, " ... We interviewed the staff and other residents on the unit (3 west) along with examining the medical chart. The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident [Resident #105] in question. Therefore, the case has been unsubstantiated due to these findings."	L 001	**B. Under 42 CFR §483.25, F686, Treatment/Services to Prevent/Heal PressureUlcers** 1. Corrective action for resident Residents #87, #83, #73, #62, and #42 were assessed on 9/8/2021 to ensure that any changes in skin condition were identified and treated appropriately. Resident #87 no longer resides in the facility. Staff were educated on identifying and reporting changes in skin conditions. 2. Identify other residents Facility completed house wide skins assessments by 9-09-2021, going forward skin assessments will be performed twice a week by the License Nursing staff during the residents showers/bed baths to document any changes in the resident' s skin condition. 3. Systemic changes The assessments will be documented and stored in the departmental shower books and the DON/Designee will audit for completion twice a week for two months. The corporate wound nurse or designee will in-serviceAll Nursing staff including registry on the process of reporting head and toe assessment and reporting documenting changes in residents skin condition to the Physician and wound team as soon as identified. An in-service including a sign-in sheet will be provided to track Nursing staff. All Nursing Staff including registry will	09/15/2021

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L 001	Continued From page 6 On 08/27/2021, a complaint was received by the State Agency that documented, "[Resident name]...The residents daughter reported to the Ombudsman ... C.N.A. (Certified Nurse's Aide) ... told the resident 'she caused him three days of pay, and that she talks too much." Review of Resident #105's Significant Change Minimum Data Set (MDS) dated 07/13/2021, revealed that facility staff coded the following: In Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) score "15", indicating intact cognitive response. In Section E (Behavior), Hallucinations (perceptual experiences in the absence of real external sensory stimuli) "No"; Delusions (misconceptions or beliefs that are firmly held, contrary to reality) "No"; and in Section GG (Functional Abilities and Goals), Toileting hygiene "... total dependence ... one-person physical assist". During a face-to-face interview conducted on 08/30/2021 at 9:06 AM, Employee #1 (Administrator) stated, "The staff member [Employee #5] and the Nurse Supervisor knew not to assign him to work with the resident (Resident #105). There was obviously a breakdown in the system. The involved CNA was floated to 3 west (where Resident #105 resided). He was not originally assigned to that unit. He [Employee #5] reported that he did not say anything to [Resident #105] while he was providing care. The supervisor is getting reprimanded, and the involved CNA was suspended (on 08/27/2021) and is being terminated as of today."	L 001	be in-serviced on Wound Policy and procedures.The Corporate wound nurse will educate the Director of Nursing on the Wound policy and procedures. 4. Monitor corrective actions Turning and repositioning will be monitored every two hours by the nursing supervisor to ensure proper turning and repositioning is being conducted. A turning and reposition audit tool will be used to monitor turning and reposition. Wounds found during the skin assessments a RCA (Root Cause Analysis) to investigate the Nursing staff responsible for not properly documenting skin assessments, and conducting turning and repositioning. This will be monitored by The Director of Nursing and Nursing Supervisors. A "skin tag violation card" will be implemented to address any staff found not doing proper turning and repositioning of residents. Nursing staff with over3 violations will be taken off the floor immediatelyfor training and a weekly Quality Audit will be conducted by the QAPI team. All finding will be addressed at the weekly QAPI meeting for 2 months. QA Audits of skin assessment documentation done weekly for two months to ensure skin assessments will be completed to ensure timely and appropriately. This will be monitored by the Administrator, Director of Nursing and the Quality Director and addressed in the weekly QAPI meetings.	

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L 001	Continued From page 7 During a face-to-face interview conducted on 08/30/2021 at 9:17 AM with Employee #2 (Director of Nursing), she stated, "We don't tolerate abuse. I do hand-off (transfer of patient care and responsibility from one healthcare provider to another) communication with the supervisors during the week. The supervisors were made aware that the CNA involved was not to work on the third floor at all." During a telephone interview conducted on 08/30/2021 at 10:36 AM, Employee #6 (Nurse Supervisor) stated, "The CNA [Employee #5] was floated to 3 west because we didn't have a CNA for that unit. I was told that the CNA shouldn't be floated to 3 east. I was not made aware about the issues on 3 west." During a telephone interview conducted on 08/30/2021 at 10:50 AM, Employee #5 stated, "I was working on 2 East and was pulled to 3 West because they were short. I was told the investigation was resolved and no issues were found, so I went to the unit (3 west). I was taking care of the roommate (room 333 bed B) when [Resident #105] stated that she was wet and needed assistance as well. I reminded her that she made a report on me and that I didn't want any problems. The resident stated that she wanted me to help her and so I did. There were no issues during the ADL (activities of daily living) care. I have been doing this for 17 years. I have never done anything to her nor intimidate her in any way." Review of Employee #5's personnel file on 09/08/2021 revealed a form entitled; "[Facility's Name] Employee Warning Notice" dated 07/29/2020. The form revealed that Employee #5 received a verbal warning on (07/16/2020) and a	L 001	The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is September 15, 2021. **C. Under 42 CFR §483.10(c)(6), F578, Request/Refuse/Discontinue Treatment;Formulate Advance Directive:** 1. Corrective action for resident Resident #105 no longer resides in the facility. Residents' #3, #5, #21, #37, #76, and #95 and/or their representatives have been given the opportunity to exercise their rights to formulate Advance Directives and Staff have validated corresponding orders. 2. Identify other residents An audit of all resident's Advance Directives was completed. There were no additional findings related to this citation. 3. Systemic changes Social Services staff have been educated on the importance of resident's/responsible party's rights to formulate an Advance Directive and their responsibility to ensure that there is a corresponding order and armband. The Director of Social Services will be responsible for validating that all residents have been offered	11/02/2021

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L 001	Continued From page 8	L 001		

written warning on (07/20/2020) for "violation of policy/procedure".

Attached to the previously mentioned warning notice was a document written by the (previous) Director of Nursing that revealed the following:

"On the morning of July16, 2020, it was brought to the attention of the Director of Nursing by Wound Care Team member... a resident [that resided on unit 3 east] was observed with a urine filled incontinence brief on and a urine saturated Ultrasorb (under pads) in the incontinence Brief. CNA (Employee #5) ... was asked about the use of the under pads inside of the resident ' s diaper. [Employee #5] said [Resident's Name] is a heavy wetter..."

"On the morning of July 20 [2020] ... [Resident #105] had a urine stained Ultrasorb under pad taped together to form a incontinence brief and was taped to the resident's skin...[Resident 105's roommate] was observed with the same makeshift incontinence brief and in addition urine soaked towel was found between the resident's legs... This is the second occurrence within one week where [Employee #5] provided care to residents in a manner ... The type of care provided by [Employee #5] to the residents is a Type B Offense... Acting in a way that can be considered abuse or neglect, or mistreatment of a patient/resident either physically, mentally or verbally."

Review of the investigation notes and documents revealed there was no documented evidence that the facility's staff reviewed Employee #5's personnel record or implemented measures to protect all residents including Resident #105, from the potential of "abuse or neglect, or

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the opportunity to formulate an Advance Directive and have corresponding physician orders.

4. Monitor corrective actions

The Director of Social Services/Designee will complete audits of all Advance Directives on all new admissions weekly and monthly on all other residents to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is November 2, 2021.

D. Under 42 CFR §483.15, F622 Transfer andDischarge

1. Corrective action for resident

Residents #97 and #103 are currently residents in the facility. We are unable to retrospectively complete the documents. The Acute care Transfer Document Checklist has been updated to include Comprehensive Care Plan Goals.

2. Identify other residents

An audit of other residents with transfers out of the facility was conducted. Moving forward, the documents will be included in transfer packets. An audit of the Acute Care Transfer Document Checklist noted that the Comprehensive Care Plan Goals was not included in the list of documents automatically

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L 001	Continued From page 9 mistreatment of a patient/resident either physically, mentally or verbally." Additionally, Employee #5's personnel record failed to outline why the employee was not allowed to work on unit 3 East. During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #7 (Director of Human Resources) stated, "The previous disciplinary actions (that occurred in 07/2020) were not mentioned to the Director of Nursing until a meeting that occurred on 08/31/2021 when termination (of Employee #5) was discussed." During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated, "I was not aware of any previous allegations made for Employee #5 (CNA) until the meeting on 08/31/2021." During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #1 (Administrator) stated, "I was not aware of any previous allegations or disciplinary actions for the employee (Employee #5). I did not review his personnel file as part my investigation." On September 8, 2021, at 1:55 PM an Immediate Jeopardy (IJ)-"K" situation was identified. On September 8, 2021 at 7:32 PM, the facility's Administrator provided a corrective action plan to the State Agency Survey Team, which included: "1. Identified resident #105 was interviewed 9-8-2021 and signed the attestation. The identified Aide was terminated on 9-01-2021. 2. An audit will be conducted on all SNF [Skilled Nursing Facility] personnel files to identify if any have been under investigation for allegations of	L 001	to include in the transfer packet (this has been corrected). There were no additional findings related to this citation. 3. Systemic changes Nursing staff and Unit Secretaries have been educated on the updated Transfer Document Checklist and the need to include the Comprehensive Care Plan Goals in the transfer packet. The Acute Care Transfer Checklist has been updated to include the Comprehensive Care Plan Goals. The Shift Supervisors will be responsible for ensuring that Comprehensive Care Plan Goals are included in the transfer packets. 4. Monitor corrective actions The Director of Social Services/Designee will complete weekly audits of all residents transferred out of the facility to ensure that the Comprehensive Care Plan Goals were included in the transfer packet. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 001	Continued From page 10 abuse, neglect, exploitation, or mistreatment to ensure all identified corrective disciplinary and follow up interviews and investigations were completed to prevent and protect residents from further abuse, neglect, exploitation, or mistreatment from occurring. The facility will also audit all IRF's [Incidences Reported by the Facility], complaints, grievances from January of 2021 to ensure all pertinent staff and residents were interviewed to reevaluate the complaint or incident. 3. Education/Designee will in-service all staff and leadership on the Abuse Policy and procedures . All future employees with allegations of abuse, neglect, exploitation, or mistreatment will receive immediate in servicing on the facilities Abuse Policies and procedure. All future IRF allegations conclusions will be forwarded by email/writing the LNHA/HR/DON/Departmental Supervisor [Licensed Nursing Home Administrator/Human Resource/Director of Nursing] with the results and preventative measures that have been put in place to protect the resident. 4. LNHA/ Designee will conduct an audit all IRF's weekly for two months to ensure the facility has completed a thorough investigation of the alleged violation; prevented further abuse, neglect, exploitation and mistreatment from occurring while the investigation was in progress; and took appropriate corrective action, as a result of investigation findings. Results of finding will be forward to QAA for review and recommendations. 5. All actions to be completed by 9-15-2021" The State Agency Survey Team returned to the facility and verified that the plan of correction was in place on 09/16/2021, at 7:52 PM, and the	L 001	**E. Under 42 CFR §483.20, F641, Accuracy of Assessments** 1. Corrective action for resident Resident #87's MDS was corrected. The resident is no longer residing in the facility. 2. Identify other residents An audit of all current residents MDSs revealed that cognitive statuses were correct. There were no additional findings related to this citation. 3. Systemic changes IDT team has been educated on the importance of ensuring that resident's cognitive status is correctly documented in the MDS. The Director of Reimbursement will be responsible for ensuring that resident's MDSs accurately reflect their cognitive status. 4. Monitor corrective actions The Director of Reimbursement/Designee will complete random weekly audits of 10% of the resident's MDSs to ensure that mental status is documented correctly. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	11/02/2021

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L 001	Continued From page 11 Immediate Jeopardy was removed. B.Under 42 CFR §483.25, F686, Treatment/Services to Prevent/Heal Pressure Ulcers Concerns were based on observation, record reviews and staff interviews, facility staff failed to ensure that sufficient nursing time was given to ensure that nursing staff were reporting and documenting changes in resident skin condition as so identified. Subsequently, five (5) of five (5) residents identified by the facility as high risk for developing pressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and Unstageable). (Residents' #87, #83, #73, #62, and #42) Due to these failures an immediate jeopardy situation was identified on September 8, 2021 at 2:01 PM. The facility submitted a plan of action to the survey team on site at 7:31 PM on September 8, 2021 and the plan was accepted. The survey team returned on September 16, 2021 to validate the facility's plan, and the immediate jeopardy was lifted on September 16, 2021 at 7:52 PM. After removal of the immediacy, the deficient practice remained at a potential for more than minimal harm for all remaining residents at a scope and severity of H. The findings include: Review of the facility policy entitled, "Prevention of Pressure Ulcers/Injuries" with a revision date of 07/2017 revealed the policy instructed staff to, " ...Inspect the skin on a daily basis when performing or assisting with personal care or	L 001	**F. 42 CFR §483.35 (g)(1)-(4) F732, Posted Nurse Staffing Information** 1. Corrective action for resident Daily Nurse Staffing is now posted as required on each unit. 2. Identify other residents All residents could have been affected. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that the daily nurse staffing information is posted on each unit. The Director of Nursing will be responsible for ensuring that the information is posted as required. 4. Monitor corrective actions The Director of Nursing/Designee will complete random weekly audits of each unit to ensure that the required daily nurse staffing information is posted as required. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	11/02/2021

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L 001	Continued From page 12 ADLs (Activities of Daily Living) ... turn and reposition bedbound resident at least every two hours ..." 1. Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including: Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer, Unstageable Right Heel Pressure Ulcer and a Stage 2 Left Heel Pressure Ulcer. Review of the Care Plan revealed the following focus: "Anti-coagulant Therapy" with a revision date of 11/20/2020. Intervention: "... daily skin inspections ..." Review of the medical record revealed the following: -02/26/2021 Physician's order- Turn and reposition every 2 hrs (hours) and as needed to prevent pressure injury. Every day and night shift. [Facility staff worked 12-hour shifts]. -02/26/2021 Physician's order- Daily head to toe skin assessments Q (every) shift. Notify MD/NP (medical doctor/nurse practitioner) of any abnormalities and document your assessment -03/19/2021 Braden Scale - [Resident #87] scored an "8" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries. -05/04/2021 Skin & Wound Evaluation - "Pressure (injury), Stage 4 (full-thickness skin	L 001	**G. 42 CFR §483.80 (d) (1)(2) F883, Influenza andPneumococcal Immunizations** 1. Corrective action for resident Residents #21 and #95 have been offered the Influenza and Pneumonia vaccines and vaccines have been administered as appropriate. Resident #105 no longer resides in the facility. 2. Identify other residents An audit of all current residents has been completed. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents are offered vaccines and ensuring that the residents and/or their responsible party are given information/education regarding the benefits and risks of immunization. The Director of Nursing will be responsible for ensuring that vaccines are offered with information/education regarding the benefits and risks of immunization. 4. Monitor corrective actions The MDS Nurse/Designee will complete weekly audits of vaccination reports to ensure that vaccines are being offered and the medical records of residents with new vaccinations to ensure that information/education regarding the benefits and risks of immunization. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.	11/02/2021

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L 001	Continued From page 13	L 001	The QAPI Committee is responsible for the on-going monitoring for compliance.	

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and tissue loss), Left ear, new, in-house acquired, wound measurements - length 0.9 cm (centimeters), width 0.9 cm, depth not applicable, undermining not applicable, tunneling not applicable, wound bed-100% granulation, exudate - light, serosanguineous, no odor .... Resident seen by wound care staff for weekly assessment. Stage 4 pressure injury to left ear ..."

-06/19/2021 Braden Scale - [Resident #87] scored an "8" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries.

-07/02/2021 weight record: "265.9 [pounds]".

-07/06/2021 Skin & Wound Evaluation - "Pressure (injury), Unstageable (Obscured full-thickness skin and tissue loss), Right calf lateral, new, in-house acquired, wound measurements - length 3.0 cm (centimeters), width 2.9 cm, depth not applicable, undermining not applicable, tunneling not applicable, wound bed-100% slough (a mass of dead tissue in, or cast out from, living tissue), exudate - none .... Resident seen by wound care staff for weekly assessment ... Noted new pressure injury to right lateral calf, unit manager made aware ...."

Review of the Treatment Administration Record (TAR) for May, June and July 2021 showed nurses signed their initials indicating that they had conducted head to toe skin assessments for Resident #87 twice a day (day and night shift).

Review of all progress notes (nursing, physician, dietary) from 04/19/2021 to 05/03/2021 and 06/21/2021 to 07/05/2021 lacked documented evidence that Resident #87's Stage 4 Left Ear

Provider's plan of correction (L 001):

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is November 2, 2021.

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L 001	Continued From page 14	L 001		

pressure (injury) and the Unstageable Right Calf pressure (injury) were observed by staff prior to the assessments conducted by the wound team on 05/04/2021 and 07/06/2021 [when the wounds were first observed at an advanced stage].

Review of the Significant Change Minimum Data Set (MDS) dated 07/29/2021 revealed the following: In Section C (Cognitive Patterns) the BIMS (Brief Interview for Mental Status) summary Score was blank. In Section G (Functional Status - Bed mobility), the resident was coded as "4" and "2" indicating that the resident was totally dependent on the staff and required one-person physical assist for bed mobility. In section M (Skin Condition), the resident was coded for have one (1) Stage 3 pressure ulcer, one (1) Stage 4 pressure ulcer, one (1) unstageable pressure ulcer and one (1) unstageable Deep Tissue Injury.

Further review of the care revealed the following focus: "Pressure Injury (Stage 4 left ear, Stage 4 sacrum, Stage 2 right heel, and Unstageable right lateral calf)" with a revision date of 07/30/2021. Interventions: "... the resident needs total assistance to turn/reposition at least every 2 hours, more often as need..."

On 08/25/2021 at approximately 3:30 PM, Employee #16 (Unit Manager) and Employee #20 (Registered Nurse) were observed providing wound care for Resident #87's Stage 4 sacral pressure injury/wound, Stage 4 Right Calf pressure injury/wound, and Right Heel Deep Tissue Injury.

During an observation on 08/26/2021 from 8:10 AM to 12:40 PM (4 ½ hours) the following was noted:

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L 001	Continued From page 15 -At 8:10 AM, Resident #87 was observed in her room, in bed, laying on her right side. -At 10:46 AM, Resident #87 remained in bed, lying on her right side. -At 12:40 PM, Resident #87 was observed to still be lying on her right side in the bed. During the four and half hours of the observation, facility staff failed to reposition Resident #87. Although the facility's nursing staff documented that they conducted head-to-toe assessments on the resident daily, there was no evidence that facility staff identified changes in the residents ' skin condition and failed to implement approaches identified in the resident's care plan (turn and reposition). Subsequently, Resident #87 developed in-house acquired wounds (Left ear and Right Calf Lateral) Stage 4 pressure injuries/ulcers. During a face-to-face interview conducted on 08/26/2021 at 12:45 PM, Employee #16 (Registered Nurse) stated, "The resident should be turned and repositioned every 2 hours and as needed. The CNA (certified nurse's aide) is working her way down to the resident's room now to provide care." It should be noted that Resident #87''s left calf Stage 4 pressure injury/ulcer required bedside serial excisional debridement (the use of a scalpel to remove devitalized [slough/necrotic] tissue) on 08/31/2021. During a face-to-face interview conducted on 09/08/2021 at approximately 10:00 AM,	L 001		

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Employee #2 (Director of Nursing) was asked how did residents' wounds (pressure injuries) get to advanced stages before staff (wound team) observed them, Employee #2 stated, "I'm looking for nursing staff to have good assessment skills. I believe that there is a need for (nursing) training." When asked how often IS residents' skin assessed by nursing staff, Employee #2 stated that nursing staff assess residents' skin at least twice-a-week during bathing times.

During a face-to-face interview conducted on 09/08/2021 at approximately 5:30 PM, Employee #15 (Registered Nurse) was asked how often does she assess residents' skin, the employee stated that she conducts a head-to-toe assessment of the residents one (1) to two (2) times per shift depending on her workload. When asked if she noticed any new skin integrity issues with Resident #87 in the months of May 2021 and July 2021, the employee stated, "No".

During a face-to-face interview on 09/08/2021 at approximately 5:30 PM, Employee #14 (Unit Manager/ RN) was asked how often she assess' residents' skin. The employee stated that when she is assigned a team, she conducts a head-to-toe assessment of the residents every shift. When asked if she noticed any new skin integrity issues with Resident #87 in the months of May 2021 and July 2021, the employee stated, "No".

2. Resident #83 was re-admitted to the facility on 07/20/2021 with diagnoses that included: Acute and Chronic Respiratory Failure with Hypoxia, Tracheostomy, Gastrostomy, Hypertension, Cerebral Infraction Affecting Right Dominant Side, and Pressure Ulcer Stage 4.

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L 001	Continued From page 17 According to the Admission MDS dated 07/20/2021, Resident #83 was coded as "rarely/never understood" under Section C (Cognitive Patterns). Under Section G (Functional Status), G0400, the resident was coded as "total dependence" on staff for bed mobility, eating toilet use, and personal hygiene, G0400, "Functional Limitation in Range of Motion" the resident was coded for "no impairment to upper and lower extremities". In Section M (Skin Conditions), the resident was coded as at risk for pressure ulcer/injury and one (1) unhealed pressure ulcer that was present on admission to the facility. According to the Braden Scale, on 07/21/2021 the resident was assessed and scored at a "10" indicating that the resident was "high risk" for skin breakdown. Review of the care plans showed the following: Focus area, " ... Stage 4 pressure injury to the sacrum"; Interventions: "the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested dated 07/21/2021." Focus area, " ... ADL self-care performance deficit r/t (related to) CVA (cerebral vascular accident), MI (myocardial infarction), Impaired cognition ..." Interventions: "Skin Inspection: the residents skin requires skin inspection q shift, observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse initiated on 7/21/2021. Review of the physician's orders show the following:	L 001		

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L 001	Continued From page 18 07/20/2021 "Daily head-to-toe skin assessment q (every) shift. Notify MD/NP for any abnormalities and document your assessment two times a day" 07/21/2021 "Turned and reposition every 2 hours and as needed to prevent pressure injury ..." 08/17/2021 "Cleanse wound right shoulder with Anasept wound cleanser spray ... then apply Anasept wound gel cover with 4x4 and secure with border gauze daily every night shift for wound care- start date" Review of the TAR from 07/20/2021, to 08/17/2021, showed that facility staff signed that they: "performed daily head to toe skin assessment Q shift (twice daily), would notify MD/NP of any abnormalities and document the assessment and turned and repositioned the resident every two hours and as needed to prevent pressure injury ..." However, review of the Skin and Wound Evaluation V5.0 form dated 08/17/2021 showed the following: "... Stage- unstageable: obscured full thickness skin and tissue loss; 22. Location: right shoulder; In-house acquired; Exact Date- [left blank]; Wound Measurements= Area-7.8 cm, length 4.3 cm x width 2.4 cm x depth not applicable ...slough- 100%, ...Progress -New ...Notes: Resident seen on wound rounds, noted new pressure injury to right shoulder, wound is 100% slough covered. Periwound area has intact blister and redness ... Facility staff were signing in the medical record that they were assessing Resident #83's skin daily and turned and repositioned the resident	L 001		

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every two hours. However, Resident #83 developed an in-house acquired pressure injury noted at an advanced stage (unstageable pressure injury to his right shoulder at the first observation and assessment).

During a face-to-face interview conducted on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents."

3. Resident #73 was admitted to the facility on 03/11/2020 with multiple diagnoses that included: Chronic Respiratory Failure, Anoxic Brain Damage and Chronic Kidney Disease.

Review of the medical record revealed the following:

03/11/2020 [Braden Scale] - Resident #73 scored a "9" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries.

04/28/2020 [Physician Order]- "Weekly skin assessment and report any abnormality to the MD (medical doctor)/NP (nurse practitioner)"

04/28/2020 [Physician Order]-"Moisturize skin with hydroguard (skin lotion) every shift"

04/28/2020 [Physician Order]- "Turn and

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L 001	Continued From page 20 reposition q (every) two hours." 04/29/2020 [Physician Order]- "Administer bed bath or sponge bath to resident daily and as needed ..." 07/19/2020 [Braden Scale] - Resident #73 scored a "9" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries. 07/30/2020- [Physician Order] - "Apply skin prep to DTI (Deep Tissue Injury) left heel twice a day, monitor, and report any redness or drainage every day and night shift for wound care." 07/30/2020 [Physician Order] - Cleanse right heel wounds with Anesept spray (wound cleanser) pat dry then apply Anesept gel (antimicrobial skin gel)... off load both heels with pillows continuously every 12 hours ..." 08/18/2020 [Skin & Wound Evaluation]- "Left lateral malleolus ... Resident seen by wound care staff for weekly assessment. New Stage 4 pressure injury noted to left malleolus area has 0.5 cm (centimeters) area of slough also able to palpate bone in wound bed. Unit manager made aware ..." "08/18/2020 [Skin & Wound Evaluation] -"Right lateral malleolus ... Resident seen by wound care staff for weekly assessment. New unstageable pressure injury to right malleolus noted. wound is dry eschar, with no redness or drainage noted at edges ..." Review of all progress notes (such as, nursing, physician, dietary) from 07/01/2020 to 08/17/2020 lacked documented evidence that Resident #73 ' s Stage 4 Left Malleolus pressure injury and the	L 001		

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Unstageable Right Malleolus pressure injury was observed by staff prior to the wound team ' s assessment on 08/18/2020.

Review of the Treatment Administration Record (TAR) from 08/01/2020 to 08/18/2020 revealed that facility staff documented that Resident #73; received a bed or sponge during the day shift, bilateral heels were off loaded during the day and at night, skin was moisturized during the day, evening and night shifts, and was being turned and repositioned every two hours at 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM and 10:00 PM.

Review of Resident #73's "CNA Activity of Daily Living (ADL) Notes" from 08/01/2021 to 08/18/2021 revealed that facility staff documented "No" to the question that asked, "Is there a new skin condition?"

Review of the Admission MDS dated 03/18/2021 revealed that facility staff coded the following:

In Section G (Functional Status), "bed mobility... total dependence... two+ (plus) persons physical assist ..."

In Section H (Bowel and Bladder), "urinary continence ... bowel continence ... always incontinent ..."

In Section M (Skin Conditions), " ... risk of pressure ulcers ...yes ..."; " ... resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/ device ...no ...", " ...is this resident at risk of developing pressure ulcers/injuries?... yes", " ... does this resident have one or more unhealed pressure

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ulcers/injuries?... no"

Review of the Care Plan revealed the following:

Focus: "Activities of Daily Living Self-care Performance Deficit" dated 03/11/2020 revealed several interventions including, "provide sponge bath when a full bath or shower cannot be tolerated ...bed mobility, and the resident is totally dependent on staff for repositioning and turning in bed every 2 hour."

Focus: "Alteration in Neurological Status" dated 03/12/2020 revealed several interventions including "... skin inspections daily and report any findings to the nurse."

Although the facility implemented approaches identified in the resident care plan (turn and reposition and inspect skin daily). Subsequently, Resident #73 developed an in-house acquired Stage 4 Left Malleolus pressure injury and a Unstageable Right Malleolus pressure on 08/18/2020.

During a face-to-face interview conducted on 09/08/2021 at approximately at 9:35 AM, Employee #9 (Director of Wound Care) stated, "The wound team has educated the nursing staff multiple times on assessment, documenting and reporting of resident ' s skin. I have brought this issue of the nursing staff not documenting or making the wound team aware of skin issues at an early stage to the attention of the Director of Nursing and the Administrator."

4. Resident #62 was re-admitted to the facility on 07/31/2021. The medical record showed the resident had several diagnoses including: Dependency on Respirator [Ventilator],

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Tracheostomy, Diabetes Mellitus, Protein-Calorie Malnutrition, Stage 4 Left Calf Pressure Ulcer, Stage 4 Scapula Pressure Ulcer, Stage 4 Left Trochanter Pressure Ulcer, Stage 3 Left Heel Pressure Ulcer, Left Foot Deep Tissue Injury, and Surgical Sacral Wound.

During an observation on 08/24/2021 starting at 12:12 PM, the wound care team provided wound care for Resident #62's wounds for the left hip, left leg, back and sacrum.

Review of the medical record revealed the following:

05/07/2021 [Braden Scale] - Resident #62 scored a "10" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries.

05/08/2021 [Physician Order] - Turn and reposition every 2hrs (hours) for comfort and to help prevent pressure injury every shift.

05/08/2021 at 4:15 AM (Nursing Admission Summary Note) - "Resident...admitted... at 7pm ...Resident has a sacral wound stage IV (4), (6cm (centimeters) X 5(cm) X 1 (cm) deep). Moderate amount of serosa (serosanguinous) drainage noted. (Left lower leg wound 0.6cm X 1.0cm). (Left buttock pressure 0.1cm)...with multiple scattered wound. Multiple scars noted to bilateral lower extremities. Old surgical sites to chest and abdomen."

05/09/2021 at 2:16 AM (Nursing Progress Note)- "Resident alert and responsive, 2nd day of readmission ...skin warm and dry to touch ...ADL and wound cares (sp) provided ... turn (sp) and reposition (sp) every two hours and as needed to prevent pressure ulcer ..."

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05/10/2021 at 1:06 PM (Nursing Progress Note) - "Resident is alert and responsive, skin warm and dry to touch ...ADL care provided, turning, and repositioning every two hours as needed to prevent pressure ulcer (sp) ..."

05/10/2021 1:58 PM (Skin & Wound Evaluation)- "new, in-house acquired, Left calf, Stage 3 (Full-thickness skin loss), pressure(injury), length 3.2 cm (centimeters), width 2.7 cm, depth 0.1 cm, undermining not applicable, tunneling not applicable. wound bed 100% granulation -pink or red, exudate light, seropurulent ..."

Review of the Treatment Administration Records for May 2021 revealed the following:

Nursing staff signed their initials indicating that they had turned and repositioned Resident #62 every (2) hours from 05/08/2021 to 05/10/2021.

Review of the Care Plans revealed the following:

Focus: "Skin Impairment related to Immobility" with am initial date of 05/07/2021, outlined multiple interventions including turn and reposition resident to prevent pressure injuries.

Review of the Minimum Data Set dated 04/21/2021 revealed, In section C (Cognitive Patterns), Brief Interview for Mental Status summary score was blank. In section G (Functional Status - Bed mobility) the resident was coded as a "4" indicating that the resident was totally dependent on the staff. The support section was left blank. In section M (Skin Condition), the resident was coded to having four (4) Stage 3 pressure ulcers, three (3) Stage 4 pressure ulcers, one (1) unstageable pressure

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L 001	Continued From page 25 ulcer and one (1) unstageable Deep Tissue Injury. Although the facility implemented approaches identified in the resident care plan (turn and reposition). Subsequently, Resident #62 developed in-house acquired wound (Left Calf) Stage 3 pressure injury within 48 hours of his re-admission date of 05/08/2021. During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #10 (Wound Team Nurse) stated that on 05/10/2021 she assessed Resident #62 ' s skin and observed an in-house acquired Stage #3 pressure injury on the resident ' s left calf. During a face-to-face interview on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents." 5. Resident #42 was re-admitted to the facility on 09/12/2020 with diagnoses that included Acute and Chronic Respiratory Failure, Type 2 Diabetes Mellitus, Tracheostomy, Gastrostomy, Hypertension, Contractures (Right and Left Elbow), and Pressure Ulcer Left Heel Stage 4. According to the Quarterly MDS dated 06/30/2021 the resident was coded as "rarely/never understood" under Section C	L 001		

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(Cognitive Patterns); Under Section G (Functional Status), G0400, the resident was coded as "total dependence" on staff for bed mobility, eating, toilet use, and personal hygiene; Functional Limitation in Range of Motion the resident was coded for "impairment to upper and lower extremities". Section M (Skin Conditions), the resident was coded as at risk for pressure ulcers and one (1) unhealed pressure ulcer.

According to the Braden Scale, Resident #42 was assessed and scored at a "9" indicating that she was "very high risk" for skin breakdown on 04/03/2021 and was assessed and scored at a "10" indicating "high risk" for skin breakdown on 07/03/2021.

Review of the care plan with the focus area, "Stage 4 pressure injury to left lateral malleolus" revealed the following interventions, "the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested" dated 07/23/2021, "Follow facility policies/protocols for the prevention/treatment of skin breakdown" initiated 12/04/2020.

Review of the physician ' s orders revealed the following:

06/11/2021 "Cleanse left medial heel wound with Anasept wound cleanser spray ... every day and PRN (as needed). Please float heels continuously to prevent pressure every night shift for wound care"

09/13/2020 "Float heels while in bed with a pillow to prevent skin breakdown and pressure every shift (day, evening , night)"

09/13/2020 "Daily head to skin assessments per

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L 001	Continued From page 27 protocol every shift and as needed, and they would notify MD (medical doctor) for any abnormality every day and night shift" 05/30/2021 "Turn and reposition every 2 hours and as needed for relieving and redistribution" Review of the Treatment Administration Record from 07/01/2021 to 07/14/2021 showed that facility staff signed that they: performed wound care to the resident ' s left heel, floated the resident ' s heels twice daily, performed head-to-toe notify MD (medical doctor) for any abnormality every day and night shift, and turned and repositioned the resident every two hours and as needed for reliving and retribution. However, review of the Skin and Wound Evaluation V5.0 form dated 07/14/2021 showed the following: "... Stage 4 full thickness and tissue loss... Location: Left Lateral Malleolus (ankle) ... Acquired; In-house acquired... Exact Date- 7/14/21; Wound Measurements= Area-2.5 cm, length 2.2cm x width 1.8 cm x 0.5 depth, undermining 1.0 cm; Wound bed -slough 100% of wound filled; exudate-light; type seropurulent; Notes: Resident seen by wound care team, noted development of new pressure injury to left lateral malleolus (sp). Wound is stage 4, full thickness with palpable bone in wound bed full description and pictures in PPC (point click care) ..." Facility staff were signing that they: conducted wound treatments to the residents left heel twice daily, were assessing the residents skin daily, floated the resident ' s heels twice daily, and turned and repositioned the resident every two	L 001		

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hours. However, Resident #42 developed an in-house acquired pressure injury noted at an advanced stage (stage 4 pressure ulcer to the Left Lateral Malleolus).

During a face-to-face interview conducted on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents."

On these findings, on September 8, 2021 at 2:01 PM an immediate jeopardy (IJ) situation was identified.

On September 8, 2021 at 7:31 PM, the facility's administrator provided a corrective action plan to the State Agency Survey team which included:

"1. Facility will complete house wide skins assessments by 9-09-2021, going forward skin assessments will be performed twice a week by the License Nursing staff during the resident ' s showers to document any changes in the resident ' s skin condition. The assessments will be documented and stored in the departmental shower books and the DON/Designee will audit for completion twice a week for two months. The corporate wound nurse or designee will in-service All Nursing staff including registry on the process of reporting head and toe assessment and reporting documenting changes in resident ' s

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L 001	Continued From page 29 skin condition to the Physician and wound team as soon as identified. An in-service including a sign-in sheet will be provided to track Nursing staff. 2. All Nursing Staff including registry will be in-serviced on Wound Policy and procedures. The Corporate wound nurse will educate the Director of Nursing on the Wound policy and procedures. 3. Turning and repositioning will be monitored every two hours by the nursing supervisor to ensure proper turning and repositioning is being conducted. A turning and reposition audit tool will be used to monitor turning and reposition. Wounds found during the skin assessments a RCA (Root Cause Analysis) to investigate the Nursing staff responsible for not properly documenting skin assessments, and conducting turning and repositioning. 4. This will be monitored by The Director of Nursing and Nursing Supervisors. A "skin tag violation card" will be implemented to address any staff found not doing proper turning and repositioning of residents. Nursing staff with over 3 violations will be taken off the floor immediately for training and a weekly Quality Audit will be conducted by the QAPI team. All finding will be addressed at the weekly QAPI meeting for two months. 5. QA Audits of skin assessment documentation done weekly for two months to ensure skin assessments will be completed to ensure timely and appropriately. This will be monitored by the Administrator, Director of Nursing and the Quality Director and addressed in the weekly QAPI meetings. All Items to be completed by	L 001		

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9-15-2021."

The State Agency Survey team returned to the facility and verified that the plan of correction was in place on September 16, 2021 at 7:52 PM, and the immediate jeopardy was removed.
C. Under 42 CFR §483.10(c)(6), F578, Request/Refuse/Discontinue Treatment; Formulate Advance Directive:

C. Concerns were based on record review and staff interview for seven (7) of 44 sampled residents, the facility's staff failed to inform residents or their representatives of their rights to formulate Advance Directives for six (6) residents and failed to confirm one (1) resident's code status. (Residents' #3, #5, #21, #37, #76, #95 and #105)

The findings include:

1. Resident #3 was admitted to the facility on 07/10/2021 with multiple diagnoses that included: Morbid Obesity, Obstructive Sleep Apnea, Cellulitis, Fibromyalgia, and Lymphedema.

Review of the Admission Minimum Data Set (MDS) dated 07/17/2021 revealed in section C (Brief Interview for Mental Status) the resident was given a summary score of "15" indicating that the resident was cognitively intact.

Review of the resident's face sheet revealed she was her own responsible party.

Review of Resident #3's medical record documented, "Full Code". However, the record lacked documented evidence that the facility's staff provided the resident with verbal or written information regarding Advance Directives.

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During a face-to-face interview on 08/31/2021 at approximately 10:30 AM, Employee #3 (Director of Social Services) stated that she had not provided the resident with information regarding Advance Directives. The employee then said, "I will offer it to her today."

2. Resident #5 was admitted to the facility on 02/22/2017, with multiple diagnoses that included: Anxiety Disorder, Depression and Tracheostomy Status.

Review of the Annual Minimum Data Set (MDS) dated 08/08/2021 revealed in Section C (Cognitive Patterns) facility staff coded Resident #5 as "severely [cognitively] impaired".

Review of Resident #5's electronic health record (EHR) and paper medical record lacked documented evidence that facility staff provided the resident's representative with information regarding formulating Advance Directives.

During a face-to-face interview conducted on 08/30/2021 at 11:32 AM, Employee #3 (Director of Social Services) stated, "Advance Directives are offered quarterly but it is not documented. Advanced Directives have not been discussed with residents or family members much during the COVID-19 Pandemic."

3. Resident #21 was re-admitted to the facility on 06/29/2021, with multiple diagnoses that included: Degenerative Joint Disease, Respiratory Failure, Dysphagia, and Cerebral Vascular Accident.

During an observation of Unit 3 West on 08/23/2021 at approximately 10:00 AM, Resident #21 was noted with a "DNR (Do Not Resuscitate)"

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bracelet on his left wrist.

Review of the Admission Minimum Data Set dated 07/07/2021, revealed in Section C (Cognitive Patterns), facility staff coded Resident #21 as, "Severely cognitively impaired".

Review of Resident #21's care plan with the focus area of: [Resident ' s name] end of life wishes are to remain a full code" revised on 05/18/2021 documented the following interventions: "IDT (interdisciplinary team) will review residents code status quarterly ... document wishes in medical record, review any existing wishes".

Continued review of Resident #21 ' s electronic and paper medical record revealed that facility staff failed to review and confirm the resident ' s code status with his representative .

During a face-to-face interview conducted on 08/30/2021 at 11:32 AM, Employee #3 (Director of Social Services) stated, "Advanced Directives are offered quarterly but it is not documented. Advanced Directives have not been discussed with residents or family members much during the COVID-19 Pandemic. "

4. Resident #37 was re admitted to the facility 09/01/2020 with multiple diagnoses that included: Anemia, Hypertension, Diabetes Mellitus, Hyperlipidemia and Cerebral Vascular Accident (CVA).

A review of the Admission Minimum Data Set (MDS) dated 08/12/2021 revealed:

In Section C (Cognitive Patterns), Resident #37 had a Brief Interview for Mental Status (BIMS) Summary Score of "15" indicating intact

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cognition.

Review of the medical record revealed a physician's order dated 11/21/2020 that directed, "Full Code."

Review of the End of Life Care Plan revised on 07/24/2021, noted, "Resident #37's end-of-life wishes will be honored. Her desire is to remain a "full code". The goal documented that the IDT (interdisciplinary team) will review the resident's goal status quarterly or if there is a change in condition.

The medical record lacked documented evidence that the facility's staff provided Resident #37 with verbal or written information regarding Advance Directives.

During a face-to-face interview conducted on 08/30/2021 at 11:22 AM, Employee #3 (Director of Social Services) stated that she did not offer the resident an Advance Directive, but she did complete the Five Wishes document (facility's document of resident's end of life wishes). The employee then said that she would ask Resident #37 about Advance Directive.

5. Resident #76 was admitted to the facility on 03/27/2020 with the following diagnoses: Anemia, Respiratory Failure, Atrial Fibrillation, Colostomy Status, and Obstructive Sleep Apnea.

A review of the Admission Minimum Data Set (MDS) dated 03/27/2020 revealed:

In Section C (Brief Interview for Mental Status), the resident was given a summary score of "12" indicating Resident #76 was mildly impaired cognitively.

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L 001	Continued From page 34 Review of the medical record revealed a physician's order dated 03/29/2021 that directed, "Code status is: DNR/DNI (Do Not Resuscitate/Do Not Intubate)". Review of the End of Life Care Plan with a revised date of 07/25/2021, noted that, "[Resident's name] end-of-life wishes are to remain DNR/DNI." One goal documented that the IDT will review the resident's goal status quarterly or if there is a change in condition. There was no documented evidence in the medical record that the facility's staff provided Resident #76 with verbal or written information regarding Advance Directives. During a face-to-face interview conducted on 08/30/2021 at 11:28 AM, Employee #3 (Director of Social Services) stated, "The resident did not have an Advance Directive, but I think she has a Medical Orders for Scope of Treatment (M.O.S.T) document." 6. Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Cerebral Infarct due to Embolism of Left Middle Cerebral Artery, Restlessness and Agitation. Review of the Admission Minimum Data Set (MDS) dated 01/26/2021, revealed in Section C (Cognitive Patterns), facility staff coded Resident #95 as "Severely [cognitively] impaired". Review of Resident #95's Electronic Health Record (EHR) and paper medical record lacked documented evidence that facility staff provided the resident's representative with information regarding formulating Advance Directives.	L 001		

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L 001	Continued From page 35	L 001		

During a face-to-face interview conducted on 08/30/2021 at 11:32 AM, Employee #3 (Director of Social Services) stated, "Advanced Directives are offered quarterly but it is not documented. Advanced Directives have not been discussed with residents or family members much during the COVID-19 Pandemic."

7. Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome.

Review of the Significant Change MDS dated 07/13/2021, revealed in Section C (Cognitive Patterns), the facility ' s staff coded the resident with a Brief Interview for Mental Status (BIMS) score of "15", indicating that the resident was cognitively intact.

Review of Resident #105's EHR and paper medical record lacked documented evidence that facility staff provided the resident with information regarding formulating Advance Directives.

During a face-to-face interview conducted on 08/30/2021 at 11:32 AM, Employee #3 (Director of Social Services) stated, "Advance Directives are offered quarterly but it is not documented. Advance Directives have not been discussed with residents or family members much during the COVID-19 Pandemic."

During the Quality Assurance and Performance Improvement (QAPI) meeting on 09/01/2021 at 2:33 PM, Employee #1 (Administrator) stated that the facility's staff had not looked at Advance Directives for most of their residents. The

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L 001	Continued From page 36	L 001		

employee then said, "We used the Medical Orders for Scope of Treatment (M.O.S.T) forms. The Advanced Directives is a federal requirement."

D. Under 42 CFR §483.15, F622 Transfer and Discharge

Concerns were based on record review and staff interview, facility's staff failed to ensure all the required documents were conveyed to the receiving health care provider for two (2) of 44 sampled residents that were transferred from the facility. (Residents' #97, and #103)

The findings include:

1. Resident #97 was admitted to the facility on 07/27/2021 with multiple diagnoses that included: Acute and Chronic Respiratory Failure and Encounter for Tracheostomy.

Review of the physician's order dated 08/17/2021 at 10:57 AM, directed, "Transfer to hospital to [Hospital's name] via 911".

Review of Resident #97's transfer documents dated 08/17/2021, lacked documented evidence that the facility's staff included the care plan goals with the resident's transfer packet.

During a face-to-face interview conducted on 08/26/2021 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated that care plan goals were not part of the documents included in the transfer packet.

2. Resident #103 was admitted to the facility on 07/21/2021 with diagnoses that included Myopathy, Gout, Acute and Chronic Respiratory

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L 001	Continued From page 37 Failure with Hypoxia, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, and Chronic Kidney Disease. Review of the resident's progress notes revealed: 07/13/2021 at 16:07 [4:07 PM] " ... new order to make arrangements for resident to be transfer to LTACH (Long Term Acute Care Hospital). Waiting for open bed they will give us a call when room available." 07/13/2021 at 21:46 [9:46 PM] "resident left the unit at 8:30 PM to LTACH I/C (Intensive Care) Unit ..." Review of the facility's "Acute Care Transfer Document Checklist" last updated June 2018 revealed the following: "Copies of Documents Sent with Resident/Patient Documents Recommended to Accompany Resident/Patient Resident /Patient Transfer Form Personal belongings identified on Resident/Patient Transfer Form are enclosed Face Sheet Current Medication List or Current MAR (Medication Administration Record) SBAR (Situation, Background, Assessment and Recommendation) and/or other Change in Condition Progress Note (if completed) Advance Directives (Durable Power of Attorney	L 001		

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L 001	Continued From page 38 for Health Care, Living Will) Advance Care Orders ... Send These Documents if available: Most Recent History and Physical Recent Hospital Discharge Summary Recent MD/NP (Nurse Practitioner) /PA (Physician ' s Assistant) and Specialist Orders Flow Sheets Relevant Lab Results ... Relevant X-rays and other Diagnostic Test Results SNF (Skilled Nursing Facility)/NF (Nursing Facility) Capabilities Checklist....." Although the facility had the aforementioned protocol for staff to complete a checklist before transferring residents, the form does not list "Comprehensive Care Plan Goals" as a document to be sent to the receiving facilities. A review of the documents [transfer packet] sent to the LTACH with Resident #103 on 07/13/2021 was conducted. There was no 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 #45 (Unit Secretary 1 South) on 08/30/2021 at 12:48 PM, and with Employee #2 (Director of Nursing) on 09/01/2021 at 8:26 AM, they both	L 001		

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L 001	Continued From page 39 acknowledged that comprehensive care plans goals are not sent to the hospital with residents when they are transferred. E. Under 42 CFR §483.20, F641, Accuracy of Assessments Concerns were based on observation, record review and interview, the facility's staff failed to ensure a Minimum Data Set Assessment accurately reflected a resident's mental status for one (1) of 44 sampled residents. (Resident #87) The findings include: Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Dependency on Respirator [Ventilator], Tracheostomy, Obesity, Gastrostomy and Stage 4 Sacral Pressure Ulcer. Review of the History and Physical dated 03/01/2021, the physician documented, " ...On February 2nd 2021 she (Resident #87) suffered a cardiopulmonary arrest ...Currently, the patient appears to be in a vegetative state and on full mechanical support (Ventilator) ..." Review of a Quarterly Minimum Data Set dated 06/02/2021 revealed, In Section C (Brief Interview of Mental Status) [BIMS] the resident was given a summary score of "11" for the indicating that Resident #87 was moderately impaired cognitively. During a face-to-face interview conducted on 09/16/2021 at approximately 12:30 PM, Employee #3 (Director of Social Services) stated	L 001		

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L 001	Continued From page 40	L 001		

that she incorrectly coded the resident's BIMS score.

F. 42 CFR §483.35 (g)(1)-(4) F732, Posted Nurse Staffing Information

Concerns were based on observation and staff interview, it was determined that the facility failed to ensure that the required daily nurse staffing information was posted.

The findings include:

An observation on unit 1 south on 08/23/2021 [08/22/2021 night shift] at 6:00 AM, revealed the posted daily nurse staffing information on the wall board across from the nurse's station on unit 1 south that was dated 08/20/2021.

However, Employee #48 (Night Supervisor) provided the surveyor with a "written" daily assignment sheet for the current shift (night dated 08/22/2021).

During a face-to-face interview conducted at the time for the observation, Employee #48 failed to provide a comment to address why the most current daily nurse staffing information was not posted (08/22/2021).

G. 42 CFR §483.80 (d) (1)(2) F883, Influenza and Pneumococcal Immunizations

Concerns were based on record review and staff interview, for three (3) of 44 sampled residents, facility staff failed to: (1) document in the resident's medical record the information/education provided regarding the

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benefits and risks of immunization. (2) ensure eligible residents received their immunizations. Residents' #21, #95 and #105.

The findings include:

Review of the facility's policy entitled, "Influenza Vaccine" revised 07/2020, revealed, "All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually ... A resident's refusal of the vaccine shall be documented on the Informed Consent for Influenza Vaccine and placed in the
resident's medical record ..."

1. Resident #21 was readmitted to the facility on 06/29/2021, with multiple diagnoses that included: Degenerative Joint Disease, Respiratory Failure, Dysphagia, and Cerebral Vascular Accident.

Review of the Admission Minimum Data Set (MDS) dated 07/07/2021, revealed that the facility staff coded the resident as follows:

In Section C (Cognitive Patterns), "Severely [cognitively] impaired"

In Section O (Special Treatments, Procedures and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" Facility staff documented "No";
"If influenza vaccine not received, state reason" facility staff documented, "Not offered";
"Is the resident's Pneumococcal vaccination up to date?" facility staff documented, "No",
"If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered".

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L 001	Continued From page 42	L 001		

Continued review of Resident #21's electronic and paper health record lacked documented evidence that facility staff provided the resident's representative with information regarding the benefits and risks of immunizations or the opportunity to receive immunizations.

2. Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Cerebral Infarc due to Embolism of Left Middle Cerebral Artery, Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy.

Review of the Admission MDS dated 01/26/2021, revealed that facility staff coded the following:

In Section C (Brief Interview for Mental Status), "Severely cognitively impaired"

In Section O (Special Treatments, Procedures and Programs), "Did the resident receive the influenza vaccine in this facility for this year's Influenza vaccination season?" facility staff documented "No";
"If influenza vaccine not received, state reason" facility staff documented, "Not offered";
"Is the resident's Pneumococcal vaccination up to date?" facility staff documented, "No",
"If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered".

Continued review of Resident #95's electronic and paper health record lacked documented evidence that facility staff provided the resident's representative with information regarding the benefits and risks of immunizations or the opportunity to receive immunizations.

3. Resident #105 was admitted to the facility on

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L 001	Continued From page 43 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome. Review of the Significant Change MDS dated 07/13/2021, revealed facility staff coded the following: In Section C (Brief Interview for Mental Status) summary score of "15", indicating intact cognitive response. In Section O (Special Treatments, Procedures and Programs), "... Is the resident's Pneumococcal vaccination up to date?" facility staff documented, "No", "If pneumococcal vaccination not received, state reason" facility staff documented, "Not offered". Continued review of Resident #105's electronic and paper health record lacked documented evidence that facility staff provided the resident with information regarding the benefits and risks of immunizations or the opportunity to receive immunizations. During a face-to-face interview conducted on 08/30/2021 at 3:39 PM, Employee #2 (Director of Nursing) stated that she would follow-up about the immunizations.	L 001		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following: (a)Making daily resident visits to assess physical and emotional status and implementing any	L 051	**L 051** **The charge nurse failed to develop and implement a baseline care plan within 48 hours ofadmission for three (3) residents.**	11/02/2021

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L 051	Continued From page 44 required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on record review and staff interview, for nine (9) of 44, sampled residents, the charge nurse failed to develop and implement a baseline care plan within 48 hours of admission for three (3) residents; failed to develop and implement comprehensive person-centered care plans for seven (7) residents; failed to revise the person-centered care plan to address resident needs and diagnoses for three (3) residents; and failed to monitor for side effects and effectiveness of the resident's prescribed psychotropic medications for depression and anxiety for one (1) resident. (Residents' #56, #68, #78, #87, #95, #100, #102, #105, and #372) The findings include:	L 051	1. Corrective action for resident The baseline Care Plans cannot be recreated retrospectively. However, comprehensive care plans are in place for Resident #95, #105, and #372. Resident #95 has a care plan in place to address the use of a hand mitten. Residents #105 and #372 no longer reside in the facility. 2. Identify other residents An audit of all new admissions baseline care plans was conducted and all current residents have had their baseline care plans in place to address pertinent resident specific concerns. There were no additional findings related to this citation. 3. Systemic changes IDT team has been educated on the importance of ensuring that baseline care plans are created for each resident within 48 hours of admission. The Director of Reimbursement will be responsible for ensuring that all residents have interim care plans within 48 hours of admission. 4. Monitor corrective actions The Director of Reimbursement/Designee will complete daily audits of all new admissions to ensure that all residents have interim care plans within 48 hours (weekend/holiday admissions will be audited the next business day). The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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L 051	Continued From page 45 The charge nurse failed to develop and implement a baseline care plan within 48 hours of admission for three (3) residents. 1. Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy. Review of the physician's orders revealed the following: 01/19/2021-"Assess left wrist restraint q (every) 2 hours and document any findings every 2 hours" 01/19/2021- "Keep left wrist restraint in place to prevent patient from pulling on her trach (tracheostomy) or G (gastrostomy)- Tube q shift" Review of Resident #95's Admission Minimum Data Set (MDS) dated 01/26/2021 revealed that facility staff coded the following: In Section P (Restraint), "Limb restraint [hand mitten] ... Used daily" During a review of Resident #95's care plan, there was no documented evidence that facility staff developed a baseline care plan (within 48 hours of admission) to address her use of a hand mitten. During a face-to-face interview conducted on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to address the findings. 2. Resident #105 was admitted to the facility on	L 051	5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 051	Continued From page 46 05/26/2021 with multiple diagnoses that included: Chronic Pain Syndrome, Polyneuropathy, Anxiety Disorder and Bipolar Disorder. Review of the physician's orders revealed: 05/26/2021 "Pain assessment every shift" 05/26/2021 "Acetaminophen (pain reliever) tablet 650 MG (milligram) give 1 tablet by mouth every 6 hours as needed for mild pain ..." 08/22/2021 "Dilaudid (opioid pain reliever) tablet 2 MG give 1 tablet by mouth every 6 hours as needed for pain" Review of the Significant Change Minimum Data Set dated 07/13/2021, revealed that facility staff coded the following: In Section J (Health Conditions), "... At any time in the last 5 days, has the resident: received scheduled pain medication regimen facility staff documented "Yes", "Received PRN (as needed) pain medications or was offered and declined Facility staff documented "Yes", "How much of the time have you experienced pain or hurting over the last 5 days" facility staff documented "Frequently ..." In Section N (Medications), "Indicate the number of days the resident received the following medications by pharmacological classification ...during the last 7 days... Medication received: "Opioid (Dilaudid)", Days: "6". During a review of Resident #105's Care Plan,	L 051	**The charge nurse failed to develop and implement comprehensive person -centered careplans. (Residents' #56, #68, #87, #95, #100, #102 and #105)** 1. Corrective action for resident Residents #56, #68, #87, #95, and #100 have had their comprehensive care plans reviewed and updated. Resident #105 no longer resides in the facility. 2. Identify other residents An audit of all current resident's care plans was conducted and all current residents have had their care plans reviewed and updated. There were no additional findings related to this citation. 3. Systemic changes IDT team has been educated on the importance of ensuring that comprehensive care plans are created for each resident and updated as needed. The Director of Reimbursement will be responsible for ensuring that all residents have comprehensive care plans. 4. Monitor corrective actions The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	11/02/2021

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L 051	Continued From page 47 there was no documented evidence that facility staff developed a baseline care plan (within 48 hours of admission) to address her pain. During a face-to-face interview conducted on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to address the findings. 3. Resident #372 was admitted to the facility on 08/10/2021, with diagnoses that included Metabolic Encephalopathy, Tracheostomy, Gastrostomy, Chronic Respiratory Failure with Hypoxia, Bacteremia, Epilepsy, Pneumonitis due to Inhalation of Food and Vomit, Schizophrenia, Anxiety Disorder, and Restlessness and Agitation. Review of the nursing progress notes revealed: 08/10/2021 at 18:26 [6:26 PM] (Admission Note) "...Resident ... admitted from [Hospital ' s name] with vent in place due to respiratory failure... PEG (Percutaneous Endoscopic Gastrostomy) tube on upper center abdomen ...Jevity 1.5 is continuous for 24 hours at 55 ml (milliliters) per hour ...condom [catheter] in place and draining clear yellow urine ..." Review of the care plan section of the electronic health record revealed there was no Baseline Care Plan developed including a focus area, goals or approaches to address Resident #372's needs for Respiratory Care/Treatment, Gastrostomy Tube Care and Enteral Feeding, and diagnoses of Schizophrenia, Anxiety Disorder, Restlessness or Agitation. Also, there was no evidence that the facility's staff provided the resident and their representative with a summary of the Baseline Care Plan.	L 051	5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 051	Continued From page 48 During a face-to-face interview conducted on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to address the findings. The charge nurse failed to develop and implement comprehensive person -centered care plans. (Residents' #56, #68, #87, #95, #100, #102 and #105) 1.The charge nurse failed to develop and implement a comprehensive person-centered care plan that included Resident #56's smoking preference. Resident #56 was admitted to the facility on 06/01/2021 with the following diagnoses: Peripheral Vascular Disease (PVD), Diabetes Mellitus, Acquired Absence of Right Foot, Opioid Dependence, Cirrhosis, Chronic Pancreatitis, Chronic Viral Hepatitis C, and Depression. During an entrance conference on 08/23/2021 at approximately 9:00 AM, Employee #1 (Administrator) stated that the facility did not have residents that smoke. Review of the care plan revealed it was last updated on 08/24/2021 lacked documented evidence the facility's staff developed a comprehensive, person-centered care plan with goals and interventions to address the resident's preference to smoke.	L 051	**The charge nurse failed to revise the person-centered care plan to address resident needs and diagnoses. (Residents' #56 #78, #87)** 1. Corrective action for resident Residents #56 and #78 have had their comprehensive care plans reviewed and updated. Resident #87 no longer resides in the facility. 2. Identify other residents An audit of all current residents care plans was conducted and all current residents have had their care plans reviewed and updated. There were no additional findings related to this citation. 3. Systemic changes IDT team has been educated on the importance of ensuring that comprehensive care plans are created for each resident and updated/revised as needed. The Director of Reimbursement will be responsible for ensuring that all residents have updated/revised comprehensive care plans. 4. Monitor corrective actions The MDS nurses will complete monthly audits of comprehensive care plans to ensure that all residents have updated/revised comprehensive care plans. Audits will be completed during resident MDS completion. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	11/02/2021

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L 051	Continued From page 49 During a face-to-face interview on 08/24/2021 at 4:01 PM, Resident #56 said that she smokes. During a face-to-face interview conducted on 08/26/2021 at 9:22 AM, Employee #23 (Unit Manager) stated that Resident #56 is a smoker and she will update the care plan to reflect the resident's preference to smoke. 2. The charge nurse failed to elevate Resident #68's Head of Bed (HOB) at a 45-degree angle while the resident's tube (enteral) feeding was infusing. Resident #68 was re-admitted to the facility on 04/19/2021. The medical record revealed that the resident had several diagnoses including Gastrostomy, Gastro-Esophageal Reflux Disease, Feeding Difficulties, Quadriplegia, Respiratory Failure, and Dependence on Respirator [Ventilator]. Observation on 08/30/2021 at approximately 2:30 PM, Resident #68 was observed lying flat in bed while her tube feeding (Glucerna 1.5 at 45 milliliters per hour) was infusing. Review of the medical record revealed the following physician orders: 04/02/2021- " ...Elevate HOB (head of bed) 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding stopped." 04/23/2021- "Enteral feed order every shift Glucerna 1.5 at 45ml/hr (milliliters/hour) X (times) 24 hr." Review of the care plan with a focus area of: Gastrostomy Tube (Enteral) Feeding dated	L 051	5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 051	Continued From page 50 04/01/21 revealed multiple interventions including ... The resident needs the HOB elevated 45 degrees during ...tube (enteral) feeding. During a face-to-face interview on 08/30/21 at approximately 2:30 PM, Employee #20 (Registered Nurse) stated that the nursing assistant had just provided care for the resident and forgot to elevate the head of the bed. 3. The charge nurse failed to develop a comprehensive person-centered care plan to address Resident #87's use of a urinary catheter and PICC (Peripherally Inserted Central Line)/mid-line (intravenous access). Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed that the resident had several diagnoses including Dependency on Respirator [Ventilator], Tracheostomy, Obesity, Gastrostomy and Stage 4 Sacral Pressure Ulcer ... During an observation of Resident #87 on 08/25/2021 at approximately 3:30PM, the resident was noted to have a urinary catheter and right upper arm PICC/MID-line. Review of the physician orders showed the following: 05/31/2021- "Change Foley (urinary) catheter every month ..." 08/05/2021- "Change PICC/MID line dressing once a week ..." The medical record lacked documented evidence that the facility's staff developed care plans to address the resident's use of a urinary catheter	L 051	**The charge nurse failed to monitor for side effectsand effectiveness of the resident's prescribed psychotropic medications for depression and anxiety Resident #100** 1. Corrective action for resident Residents #100 is currently being assessed for the effectiveness of their psycho tropic medications. They have also been evaluated by a psychiatrist. 2. Identify other residents An audit of other residents on psychotropic medications and orders for psychiatric evaluations has been completed. Residents have been evaluated as needed and are being assessed for effectiveness of their psychotropic medications. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents received ordered medical evaluations and are evaluated for the effectiveness of their medications. The Director of Social Services will be responsible for ensuring that residents are evaluated by the psychiatrist per physician orders and that the effectiveness of the psychotropic medications is assessed. 4. Monitor corrective actions The Director of Social Services/Designee will complete weekly audits of Behavior Monitoring sheets of all residents on psychotropic medications to ensure that they are assessed for the effectiveness of their medications and that	11/02/2021

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L 051	Continued From page 51 and a PICC/MID-line. During a face-to-face interview on 09/01/2021 at approximately 11:00 AM, Employee #14 (Unit Manager) stated that she would develop a care plan to address Resident #87's use of a urinary catheter and a PICC/MID line. 4. The charge nurse failed to develop a comprehensive, person-centered care plan to address Resident #95's use of a hand mitten. Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy. Review of Resident #95's Admission Minimum Data Set (MDS) dated 01/26/2021, revealed that facility's staff coded the following: In Section P (Restraint) "Limb restraint [hand mitten] ... Used daily" Review of the physician's orders revealed the following: 01/19/2021- "Assess left wrist restraint q (every) 2 hours and document any findings every 2 hours " 01/19/2021- "Keep left wrist restraint in place to prevent patient from pulling on her trach (tracheostomy) or G (gastrostomy)- Tube q shift" Review of Resident #95's care plan revealed there was no documented evidence that the facility's staff developed a comprehensive, person-centered care plan with goals and	L 051	they have been evaluated by a psychiatrist as ordered. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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interventions to address the resident's use of a hand mitten.

During a face-to-face interview on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to address findings.

5. The charge nurse failed to develop a care plan to address Resident #100's diagnosis of Anxiety.

Resident #100 was admitted to the facility on 04/26/2021, with multiple diagnoses that included Anxiety and Depression...

Review of physician orders revealed the following:

04/26/2021- "Diazepam (antianxiety) Tablet 5 mg (milligram) give 1 tablet via G (gastrostomy) tube every twelve hours for anxiety ..."

04/27/2021- "Antipsychotic medication- monitor for dry mouth, constipation, blurred vision, disorientation/confusion, difficulty urinating, hypotension, dark urine, yellow skin.

07/09/2021- "Quetiapine Fumarate (antipsychotic) Tablet 25 mg give 3 tablet via G (Gastrostomy) -tube every 8 hours for Depression ..."

07/15/2021-"Klonopin (antianxiety) ... give 1 tablet via G-tube two times a day for Anxiety ..."

Review of the Quarterly MDS dated 08/02/2021 showed that in Section C (Cognitive Patterns), C0100 "Should a Brief Interview for Mental Status be conducted" facility staff coded, "0" meaning "Resident is rarely/never understood". Section D

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(Mood) Facility staff coded "0"(meaning no symptoms present). In Section E (Behavior - Potential Indicators of Psychosis) facility staff coded, "Z" indicating none of the above. In Section "I" (Active Diagnosis) facility staff coded Anxiety Disorder and Depression.

Review of Resident #100's care plans lacked documented evidence that the facility's staff developed a comprehensive person-centered care plan to address Resident 100's diagnosis of Anxiety.

During a face-to-face interview on 09/16/2021, Employee #42 (Unit Manager) stated that she is responsible for the care plan. However, the employee failed explain why the resident's anxiety diagnose was not address in the previously mentioned care plans.

6. The charge nurse failed to update Resident #102's care plan to address his needs for mental health care.

Resident #102 was admitted to the facility on 05/12/2021, with multiple diagnoses including, Multiple Fractures of Ribs, Acute Chronic Respiratory Failure with Hypoxia, Unspecified Fracture of Lower End of Right Femur, and Pressure Ulcer of Sacral Region.

Review of the nursing progress notes dated from 07/07/2021 to 07/31/2021 revealed the following:

07/01/2021 at 5:27 AM- "Refused wound care, stated "don't you touch my wounds they are already done" resident was educated the importance of wounds being done but refused"

07/07/2021 at 6:14 PM- "Resident refused to

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have his wound VAC (a type of therapy to help wounds heal ...device decreases air pressure on the wound this can help the wound heal more quickly ...)" done writer made attempts to do the wound, but he refused care as well as therapy. He indicated that he does not want to be bothered."

https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/vacuumassisted-closure-of- a-wound

07/26/2021 at 9:25 PM -"resident refused fs [finger stick] check and insulin. risk and benefit explained to resident"

07/27/2021 at 7:35 AM - "...patient refused morning care he said it is too early for him to get cleaned..."

07/27/2021 at 6:58 PM - " Resident refused, stated I do not need any pain medication [Oxycodone (opioid pain reliever)...5 MG Give 1 tablet via G (gastrostomy)-Tube every day and night shift for Prior to wound care] ..."

Review of Resident #102 ' s comprehensive care plan lacked documented evidence that the facility ' s staff developed a person-centered care plan to address his refusal of care.

During a face-to-face interview conducted on 09/16/2021 at approximately 3:15 PM, Employee #14 (Unit Manager) stated that she was not sure if the resident was evaluated by a Psychiatrist to address his refusal of care.

7. The charge nurse failed to develop a comprehensive, person-centered care plan to

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L 051	Continued From page 55 address Resident #105's pain. Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Chronic Pain Syndrome, Polyneuropathy, Anxiety Disorder and Bipolar Disorder. Review of the Significant Change MDS dated 07/13/2021, revealed that facility staff coded the following: In Section J (Health Conditions), "... At any time in the last 5 days, has the resident: received scheduled pain medication regimen facility staff documented "Yes", "received PRN (as needed) pain medications or was offered and declined" facility staff documented "Yes", "How much of the time have you experienced pain or hurting over the last 5 days" facility staff documented "Frequently ..." In Section N (Medications), "Indicate the number of days the resident received the following medications by pharmacological classification ...during the last 7 days... Medication received: "Opioid (Dilaudid)", Days: "6". Review of the physician's orders revealed the following: 05/26/2021- "Pain assessment every shift" 05/26/2021- "Acetaminophen (pain reliever) tablet 650 MG (milligram) Give 1 tablet by mouth every 6 hours as needed for mild pain ..." 08/22/2021- "Dilaudid (opioid pain reliever) tablet 2 MG Give 1 tablet by mouth every 6 hours as needed for pain" During a review of Resident #105's care plan,	L 051		

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L 051	Continued From page 56 there was no documented evidence that facility staff developed a baseline care plan (within 48 hours of admission) to address her pain. During a face-to-face interview conducted on 08/30/2021 at 10:35 AM, Employee #2 (Director of Nursing) failed to provide any comments to the findings. The charge nurse failed to revise the person-centered care plan to address resident needs and diagnoses. (Residents' #56 #78, #87) 1A. The charge nurse failed to revise and update the comprehensive care plan to address Resident's #56 discontinued use of an indwelling urinary catheter. Resident #56 was admitted to the facility on 06/01/2021 with the following diagnoses: Peripheral Vascular Disease , Diabetes Mellitus, Acquired Absence of Right Foot, Opioid Dependence, Cirrhosis, Chronic Pancreatitis, Chronic Viral Hepatitis C, and Depression. Review of the Quarterly Minimum Data Set dated 07/19/2021 revealed in Section C (Cognitive Patterns), that Resident #56 was documented as having a Brief Interview for Mental Status Summary Score of "15" indicating the resident was intact cognitively. In Section H (Bowel and Bladder), the resident was not coded for the use of an indwelling urinary catheter. During a tour of the facility on 08/23/2021 at 9:04 AM, Resident #56 was observed lying in bed,	L 051		

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watching television. At the time of the observations, the resident did not have an indwelling urinary catheter.

Review of the physician's order dated 06/02/2021, directed, "Change foley catheter, "q (every) monthly and as needed." This order was discontinued on 07/01/2021.

Review of the care plan revealed a focus area of: " The resident has urinary retention related to presence of foley catheter." initiated on 06/03/2021. At the time of this review, (08/26/2021) Resident #56 no longer had the indwelling urinary catheter in place. However, the care plan was not updated to reflect the resident's current urinary status.

During a face-to-face interview on 08/24/2021 at 4:01 PM, Resident #56 stated, "I had "one" [indwelling urinary catheter] a few months ago, but it was removed."

During a face-to-face interview on 08/26/2021 at 1:07 PM, Employee #23 (Unit Manager) stated that she would remove it (urinary retention related to presence of foley catheter care plan) from the resident's comprehensive care plan.

2. The charge nurse failed to revise and update the comprehensive care plan for Resident #56 after a fall/accident on 08/03/2021.

Review of a nursing progress note dated 08/03/2021 at 15:36 (3:36 PM), documented, " It was reported ...that [Resident's name] fell out of her wc (wheelchair) [while] off the property...resident was navigating her electric wheel chair in the parking lot...she fell while

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backing up and a person walking by and a metro access driver helped her up...[resident] states I have a scratch on my arm... refused ...medical attention."

Review of the care plan with a revision date of 08/24/2021 with the focus area: "...at risk for fall..." However, the last update on 08/24/2021 failed to address Resident #56's fall on 08/03/21.

During a face-to face interview with Employee #23 at 9:22 AM, acknowledged that Resident #56 had a fall on 08/03/2021 and that the care plan for Resident #56 had not been updated to include the recent fall.

3. The charge nurse failed to update and revise Resident #78's care plan to include all of the diagnoses.

Resident #78 was admitted to the facility on 04/14/2020, with multiple diagnoses including, Depression, Bipolar Disorder, Anoxic Brain Damage, and Acute and Chronic Respiratory Failure.

Review of the Quarterly Minimum Data Set (MDS) dated 08/22/2021, showed that in Section C (Cognitive Patterns), C0100 asked, "should a brief interview for mental status be conducted" facility staff coded "0" indicating "no". In Section I (Active Diagnosis) Resident #78, was coded as having Depression, Bipolar Disorder and Anoxic Brain Damage.

Review of the document entitled "History and Physical" revealed the following:

04/15/2020 - "... history of present illness", "

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L 051	Continued From page 59 ...H/O (history of) ...Bipolar Disorder, Depression and PCP (Phencyclidine or Phenylcyclohexyl Piperidine) [a hallucinogenic drug] use ..." 05/17/2021- "... history of present illness", "h/o Depression, Bipolar, Anoxic Brain Damage ..." Review of Resident #78's "Comprehensive Care Plan" dated 08/18/2021, failed to have focus areas that addressed the resident ' s diagnoses of Depression and Anoxic Brain Damage. During a face-to-face interview conducted on 09/16/2021, Employee #42 (Unit Manager) stated that she is responsible for updating the care plan. 4. The charge nurse failed to revise Resident #87's care plan with new interventions to address the resident's skin integrity issues. Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including: Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, and Obesity During an observation on 08/25/2021 at approximately 3:30 PM, Employee #16 (Unit Manager) and Employee #20 (Registered Nurse) were observed providing wound care for Resident #87's Stage 4 sacral pressure injury/wound, Stage 4 Right Calf pressure injury/wound, and Right Heel Deep Tissue Injury. Review of Skin &Wound Evaluation sheets	L 051		

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L 051	Continued From page 60 revealed the following: 04/28/2021-new, in-house acquired, right buttocks blister, length 4.2cm (centimeters),width 1.1 cm, depth not applicable, undermining not applicable, tunneling not applicable. It should be noted that staff is currently classifying this wound as a Stage 4 (full thickness skin and tissue loss) pressure injury. 05/04/2021 -new, in-house acquired, Stage 4 pressure injury to left ear, length 0.9cm, width 0.9 cm, depth not applicable, undermining not applicable, tunneling not applicable. 05/18/2021 - new, in-house acquired, right heel blister, length 4.1cm, width 4.3 cm, depth not applicable, undermining not applicable, tunneling not applicable. It should be noted that staff is currently classifying this wound [right heel] as a Deep Tissue Injury (persistent non-blanchable deep red, maroon, or purple discoloration). 07/06/2021- new, in-house acquired, right calf unstageable (obscured full-thickness skin and tissue loss) pressure ulcer/injury, length 3.0 cm, width 2.0 cm, depth not applicable, undermining not applicable, tunneling not applicable, and wound bed - 100% of wound filled with slough (a mass of dead tissue). Review of physicians orders revealed the following: 05/18/2021- directed, "Cleanse blister right heel gently with wound cleanser spray, pat dry, apply skin prep twice a day to protect ...Every day and	L 051		

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L 051	Continued From page 61	L 051		

night shift for wound care."

05/21/2021 - directed, "Cleanse wound left ear with wound cleanser spray, pat dry, apply Exuderm RCD (Regulated Colloidal Dispersion), change every three days every night ...for wound care."

05/21/2021 - directed, "Cleanse wound to sacrum with Anasept wound cleanser spray, pat dry, apply Anasept gel, cover with 4X4's and pad, and secure with coversite [stratasorb] dressing daily and prn (as needed) every night shift for wound care".

07/07/2021 - directed," Cleanse wound to right calf with Anasept wound cleanser spray, pat dry, apply Anasept gel, cover with 4 X 4's, abd (abdominal) pad, wrap with kling daily and prn (as needed)."

Review of the June 2021 and July 2021 Treatment Administration Record (TAR) revealed that nursing staff initialed the TAR from 06/01/2021 to 07/29/2021indicating that they were providing wound care as prescribed.

Review of the Quarterly Minimum Data Set (MDS) dated 06/02/2021 revealed the following:

In Section C (Brief Interview for Mental Status) the resident was coded as an "11" indicating that the resident was moderately impaired cognitively. In Section G (Functional Status) the resident was coded as total dependent on staff and requiring physical assistance of one or two staff members for bed mobility, dressing, eating, toileting, and personal hygiene. Section I (Active Diagnoses) the resident was coded for Aphasia, Dependency on Respirator [Ventilator] Status, Tracheostomy,

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L 051	Continued From page 62	L 051		

Gastrostomy, and Generalized Muscle Weakness. In Section M (Skin Condition) the resident was coded for being at risk for pressure ulcers/injuries and having one Stage 2, one Stage 3 and one Stage 4 pressure ulcer/injury. The resident was also coded for having surgical wound(s).

Review of the Significant Change Minimum Data Set (MDS) dated 07/29/2021 revealed the following:

In Section C (Brief Interview for Mental Status) the area was blank. In Section G (Functional Status) the resident was coded as total dependent on staff and requiring physical assistance with one or two staff members for bed mobility, dressing, eating, toileting, and personal hygiene. Section I (Active Diagnoses) the resident was coded for Stage 4 Pressure Ulcer, Aphasia, Dependency on Respirator [Ventilator] Status, Tracheostomy, Gastrostomy, and Generalized Muscle Weakness. In Section M (Skin Condition) the resident was coded for: being at risk for pressure ulcers/injuries, one Stage 3 and one Stage 4 Pressure Ulcer/Injury, one Unstageable Wound, one Unstageable Deep Tissue Injury, and surgical wound(s) and In Section V (Care Area Assessment Summary) indicated that pressure ulcer care area was triggered for this assessment.

Review of the care plan with an initial date of 02/26/2021 with the focus area of:

"The resident has Stage 4 (pressure injury) to sacrum ... New pressure injury unstageable to right lateral calf...". The care plan lacked documented evidence that the facility's staff

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updated it with new (current) interventions after each assessment (06/02/2021 and 07/26/2021) to address Resident #87's skin integrity issues including pressure ulcers/injuries.

During a face-to-face interview on 09/01/2021 at approximately 1:30 PM, Employee #14 (Unit Manager) stated that she had not revised Resident #87's care plan with new interventions to address the resident's skin integrity issues, but she would update the care plan moving forward.

The charge nurse failed to monitor for side effects and effectiveness of the resident's prescribed psychotropic medications for depression and anxiety Resident #100

1.The facility's staff failed to monitor Resident #100 for side effects and effectiveness of his prescribed psychotropics medications.

Resident #100 was admitted to the facility on 04/26/2021 with multiple diagnoses including Anxiety and Depression.

Review of physician orders revealed the following:

04/26/2021- " Diazepam (antianxiety) 5 mg (milligram) 1 tablet via G(Gastrostomy) tube every twelve hours for anxiety."

04/27/2021- "Antipsychotic medication-monitor for dry mouth, constipation, blurred vision, disorientation/confusion difficulty urinating, hypotension, dark urine, yellow skin ..."

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L 051	Continued From page 64 07/09/2021-"Quetiapine Fumarate (antipsychotic) 25 mg Give 3 tablet via G-tube every 8 hours for depression." 07/15/2021- "KlonoPin (Antianxiety) Tablet 1 mg (clonazepam) Give 1 tablet via G- tube two times a day for anxiety ..." Review of the Quarterly Minimum Data Set dated 08/02/2021 showed facility staff coded the following: In Section C (Cognitive Patterns), "Should a brief Interview for Mental status be conducted", "0" meaning "Resident is rarely/never understood". In Section D (Mood). "0". In Section E (Behavior), potential indicators of psychosis, "Z", "none of the above". Review of the care plan revealed a focus area of: "[Resident's name] uses psychotropic medications r/t depression ...with a revision dated of 05/04/2021. The care plan outlined multiple interventions including monitor for side effects and effectiveness Q-Shift (Every shift)". During a face-to-face interview on 08/30/2021 at 3:31 PM, Employee #11 (Registered Nurse) stated that the last time a Behavioral Assessment was conducted for the resident was in June of 2021.	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a)Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed;	L 052	**L 052** **A.Facility staff failed to ensure that sufficient nursing time was given to ensure that nursing staff were reporting and documenting changes inresident skin condition as so identified.** **Subsequently, five (5) of five (5)**	11/02/2021

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L 052	Continued From page 65 (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1) Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair; (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by:	L 052	**residents identified by the facility as high risk for developingpressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and Unstageable). (Residents' #87, #83, #73, #62, and #42)** 1. Corrective action for resident Residents #87, #83, #73, #62, and #42 were assessed on 9/8/2021 to ensure that any changes in skin condition were identified and treated appropriately. Resident #87 no longer resides in the facility. Staff were educated on identifying and reporting changes in skin conditions. 2. Identify other residents Facility completed house wide skins assessments by 9-09-2021, going forward skin assessments will be performed twice a week by the License Nursing staff during the residents showers/bed baths to document any changes in the resident' s skin condition. 3. Systemic changes The assessments will be documented and stored in the departmental shower books and the DON/Designee will audit for completion twice a week for two months. The corporate wound nurse or designee will in-serviceAll Nursing staff including registry on the process of reporting head and toe assessment and reporting documenting changes in residents skin condition to the Physician and wound team as soon as identified.	

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L 052	Continued From page 66 Based on observation, record reviews Resident and staff interviews, 12 of 44 sampled residents, facility staff failed to ensure that sufficient nursing time was given to ensure that nursing staff were reporting and documenting changes in resident skin condition as so identified. Subsequently, five (5) of five (5) residents identified by the facility as high risk for developing pressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and Unstageable). Failed to ensure that sufficient nursing time was given to: provide adequate supervision to monitor the residents whereabout in and out of the facility for one (1) resident who left the facility without the staff knowledge; weigh a resident every 30 days as ordered and verify accurate weights were being obtained for two (2) residents'; provide respiratory care consistent with the professional standards of practice as evidenced by failure to ensure one (1) resident receiving oxygen therapy had physician's orders to direct the amount of oxygen to be delivered to the resident; change one (1) resident's colostomy bag (a plastic bag attached to the abdomen that collects fecal matter from the digestive tract through an opening in the abdominal wall called a stoma...), when it was full, in accordance with the physician's order and professional scope and standards of practice; accurately reassess and evaluate the resident pain after administering pain medication for two (2) residents'; and to ensure one (1) resident was evaluated by a psychiatrist, as ordered by the physician. (Residents' #21, #37, #42, #56, #62, #73, #76, #83, #87, #93, #95 and #102) The findings include:	L 052	An in-service including a sign-in sheet will be provided to track Nursing staff. All Nursing Staff including registry will be in-serviced on Wound Policy and procedures.The Corporate wound nurse will educate the Director of Nursing on the Wound policy and procedures. 4. Monitor corrective actions Turning and repositioning will be monitored every two hours by the nursing supervisor to ensure proper turning and repositioning is being conducted. A turning and reposition audit tool will be used to monitor turning and reposition. Wounds found during the skin assessments a RCA (Root Cause Analysis) to investigate the Nursing staff responsible for not properly documenting skin assessments, and conducting turning and repositioning. This will be monitored by The Director of Nursing and Nursing Supervisors. A "skin tag violation card" will be implemented to address any staff found not doing proper turning and repositioning of residents. Nursing staff with over3 violations will be taken off the floor immediatelyfor training and a weekly Quality Audit will be conducted by the QAPI team. All finding will be addressed at the weekly QAPI meeting for 2 months. QA Audits of skin assessment documentation done weekly for two months to ensure skin assessments will be completed to ensure timely and appropriately. This will be monitored by the Administrator, Director of Nursing and the Quality	

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L 052	Continued From page 67 A.Facility staff failed to ensure that sufficient nursing time was given to ensure that nursing staff were reporting and documenting changes in resident skin condition as so identified. Subsequently, five (5) of five (5) residents identified by the facility as high risk for developing pressure ulcers had pressure ulcers/injuries first observed by staff at an advance stage (Stage 3, Stage 4 and Unstageable). (Residents' #87, #83, #73, #62, and #42) Review of the facility policy entitled, "Prevention of Pressure Ulcers/Injuries" with a revision date of 07/2017 revealed the policy instructed staff to, " ...Inspect the skin on a daily basis when performing or assisting with personal care or ADLs (Activities of Daily Living) ... turn and reposition bedbound resident at least every two hours ..." 1. Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including: Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer, Unstageable Right Heel Pressure Ulcer and a Stage 2 Left Heel Pressure Ulcer. Review of the Care Plan revealed the following focus: "Anti-coagulant Therapy" with a revision date of 11/20/2020. Intervention: "... daily skin inspections ..." Review of the medical record revealed the following:	L 052	Director and addressed in the weekly QAPI meetings. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is September 15, 2021.	

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L 052	Continued From page 68 -02/26/2021 Physician's order- Turn and reposition every 2 hrs (hours) and as needed to prevent pressure injury. Every day and night shift. [Facility staff worked 12-hour shifts]. -02/26/2021 Physician's order- Daily head to toe skin assessments Q (every) shift. Notify MD/NP (medical doctor/nurse practitioner) of any abnormalities and document your assessment -03/19/2021 Braden Scale - [Resident #87] scored an "8" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries. -05/04/2021 Skin & Wound Evaluation - "Pressure (injury), Stage 4 (full-thickness skin and tissue loss), Left ear, new, in-house acquired, wound measurements - length 0.9 cm (centimeters), width 0.9 cm, depth not applicable, undermining not applicable, tunneling not applicable, wound bed-100% granulation, exudate - light, serosanguineous, no odor .... Resident seen by wound care staff for weekly assessment. Stage 4 pressure injury to left ear ..." -06/19/2021 Braden Scale - [Resident #87] scored an "8" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries. -07/02/2021 weight record: "265.9 [pounds]". -07/06/2021 Skin & Wound Evaluation - "Pressure (injury), Unstageable (Obscured full-thickness skin and tissue loss), Right calf lateral, new, in-house acquired, wound measurements - length 3.0 cm (centimeters), width 2.9 cm, depth not applicable, undermining	L 052	**B.Facility staff failed to ensure that sufficient nursing time was given to provide adequate supervision to monitor the residents whereaboutin and out of the facility for Resident #93 who leftthe facility without the staff knowledge** 1. Corrective action for resident Resident #93 was educated on signing out when leaving the facility. 2. Identify other residents An audit of other resident LOAs was completed. There were no additional findings related to this citation. 3. Systemic changes Nursing and security staff have been educated on the importance of ensuring that residents are signed out appropriately and accounted for and no heaters are present. Nursing staff have been educated on the importance of accurate documentation and validation of resident whereabouts throughout the shift. The Director of Security will be responsible for ensuring that residents are engaged upon exit of the facility to ensure that they have notified nursing staff of their whereabouts. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of all residents who go out on LOAs to ensure that their absence and related documentation is accurate. The	11/02/2021

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L 052	Continued From page 69 not applicable, tunneling not applicable, wound bed-100% slough (a mass of dead tissue in, or cast out from, living tissue), exudate - none .... Resident seen by wound care staff for weekly assessment Noted new pressure injury to right lateral calf, unit manager made aware " Review of the Treatment Administration Record (TAR) for May, June and July 2021 showed nurses signed their initials indicating that they had conducted head to toe skin assessments for Resident #87 twice a day (day and night shift). Review of all progress notes (nursing, physician, dietary) from 04/19/2021 to 05/03/2021 and 06/21/2021 to 07/05/2021 lacked documented evidence that Resident #87's Stage 4 Left Ear pressure (injury) and the Unstageable Right Calf pressure (injury) were observed by staff prior to the assessments conducted by the wound team on 05/04/2021 and 07/06/2021 [when the wounds were first observed at an advanced stage]. Review of the Significant Change Minimum Data Set (MDS) dated 07/29/2021 revealed the following: In Section C (Cognitive Patterns) the BIMS (Brief Interview for Mental Status) summary Score was blank. In Section G (Functional Status - Bed mobility), the resident was coded as "4" and "2" indicating that the resident was totally dependent on the staff and required one-person physical assist for bed mobility. In section M (Skin Condition), the resident was coded for have one (1) Stage 3 pressure ulcer, one (1) Stage 4 pressure ulcer, one (1) unstageable pressure ulcer and one (1) unstageable Deep Tissue Injury. Further review of the care revealed the following focus: "Pressure Injury (Stage 4 left ear, Stage 4	L 052	results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 052	Continued From page 70 sacrum, Stage 2 right heel, and Unstageable right lateral calf)" with a revision date of 07/30/2021. Interventions: "... the resident needs total assistance to turn/reposition at least every 2 hours, more often as need..." On 08/25/2021 at approximately 3:30 PM, Employee #16 (Unit Manager) and Employee #20 (Registered Nurse) were observed providing wound care for Resident #87's Stage 4 sacral pressure injury/wound, Stage 4 Right Calf pressure injury/wound, and Right Heel Deep Tissue Injury. During an observation on 08/26/2021 from 8:10 AM to 12:40 PM (4 ½ hours) the following was noted: -At 8:10 AM, Resident #87 was observed in her room, in bed, laying on her right side. -At 10:46 AM, Resident #87 remained in bed, lying on her right side. -At 12:40 PM, Resident #87 was observed to still be lying on her right side in the bed. During the four and half hours of the observation, facility staff failed to reposition Resident #87. Although the facility's nursing staff documented that they conducted head-to-toe assessments on the resident daily, there was no evidence that facility staff identified changes in the residents ' skin condition and failed to implement approaches identified in the resident's care plan (turn and reposition). Subsequently, Resident #87 developed in-house acquired wounds (Left ear and Right Calf Lateral) Stage 4 pressure injuries/ulcers.	L 052	**C. Facility staff failed to ensure that sufficient nursing time was given to weigh a resident every30 days as ordered and verify accurate weights were being obtained. Residents' #37 and #95.** 1. Corrective action for resident Residents #37 and #95 have been weighed per their physician's orders. 2. Identify other residents An audit of other residents with orders for weights has be completed and all residents have been weighed and their weights documented and verified. There were no additional findings related to this citation. 3. Systemic changes Nursing staff and the Dietician have been educated on the importance of ensuring that residents are weighed and weights documented per physician orders. The Dietician will be responsible for ensuring that residents are weighed and weights documented and verified. 4. Monitor corrective actions The Dietician/Designee will complete weekly audits of all residents with orders to be weighed to ensure that weights are obtained, documented, and verified. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	11/02/2021

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	HFD02-0023	A. BUILDING: ______ B. WING ______	C 09/16/2021

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L 052	Continued From page 71 During a face-to-face interview conducted on 08/26/2021 at 12:45 PM, Employee #16 (Registered Nurse) stated, "The resident should be turned and repositioned every 2 hours and as needed. The CNA (certified nurse's aide) is working her way down to the resident's room now to provide care." It should be noted that Resident #87''s left calf Stage 4 pressure injury/ulcer required bedside serial excisional debridement (the use of a scalpel to remove devitalized [slough/necrotic] tissue) on 08/31/2021. During a face-to-face interview conducted on 09/08/2021 at approximately 10:00 AM, Employee #2 (Director of Nursing) was asked how did residents' wounds (pressure injuries) get to advanced stages before staff (wound team) observed them, Employee #2 stated, "I'm looking for nursing staff to have good assessment skills. I believe that there is a need for (nursing) training." When asked how often IS residents' skin assessed by nursing staff, Employee #2 stated that nursing staff assess residents' skin at least twice-a-week during bathing times. During a face-to-face interview conducted on 09/08/2021 at approximately 5:30 PM, Employee #15 (Registered Nurse) was asked how often does she assess residents' skin, the employee stated that she conducts a head-to-toe assessment of the residents one (1) to two (2) times per shift depending on her workload. When asked if she noticed any new skin integrity issues with Resident #87 in the months of May 2021 and July 2021, the employee stated, "No". During a face-to-face interview on 09/08/2021 at	L 052	5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 052	Continued From page 72 approximately 5:30 PM, Employee #14 (Unit Manager/ RN) was asked how often she assess' residents' skin. The employee stated that when she is assigned a team, she conducts a head-to-toe assessment of the residents every shift. When asked if she noticed any new skin integrity issues with Resident #87 in the months of May 2021 and July 2021, the employee stated, "No". 2. Resident #83 was re-admitted to the facility on 07/20/2021 with diagnoses that included: Acute and Chronic Respiratory Failure with Hypoxia, Tracheostomy, Gastrostomy, Hypertension, Cerebral Infraction Affecting Right Dominant Side, and Pressure Ulcer Stage 4. According to the Admission MDS dated 07/20/2021, Resident #83 was coded as "rarely/never understood" under Section C (Cognitive Patterns). Under Section G (Functional Status), G0400, the resident was coded as "total dependence" on staff for bed mobility, eating toilet use, and personal hygiene, G0400, "Functional Limitation in Range of Motion" the resident was coded for "no impairment to upper and lower extremities". In Section M (Skin Conditions), the resident was coded as at risk for pressure ulcer/injury and one (1) unhealed pressure ulcer that was present on admission to the facility. According to the Braden Scale, on 07/21/2021 the resident was assessed and scored at a "10" indicating that the resident was "high risk" for skin breakdown. Review of the care plans showed the following: Focus area, " ... Stage 4 pressure injury to the	L 052	**D. Facility staff failed to ensure that sufficient nursing time was given to provide respiratory careconsistent with the professional standards of practice as evidenced by failure to ensure one (1) resident receiving oxygen therapy had physician's orders to direct the amount of oxygento be delivered to the resident. Resident #21.** 1. Corrective action for resident Resident #21 currently has an order for oxygen that matches his oxygen delivery. 2. Identify other residents An audit of other residents on oxygen did not reveal any other residents that were missing orders. There were no additional findings related to this citation. 3. Systemic changes Nursing and Respiratory Therapy staff have been educated on the importance of ensuring that residents have oxygen orders that corresponds with what they are receiving. The Director of Nursing will be responsible for ensuring that residents have orders for all modalities received. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of residents on oxygen to ensure that they have orders that match what they are receiving. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.	11/02/2021

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L 052	Continued From page 73 sacrum"; Interventions: "the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested dated 07/21/2021." Focus area, " ... ADL self-care performance deficit r/t (related to) CVA (cerebral vascular accident), MI (myocardial infarction), Impaired cognition ..." Interventions: "Skin Inspection: the residents skin requires skin inspection q shift, observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse initiated on 7/21/2021. Review of the physician's orders show the following: 07/20/2021 "Daily head-to-toe skin assessment q (every) shift. Notify MD/NP for any abnormalities and document your assessment two times a day" 07/21/2021 "Turned and reposition every 2 hours and as needed to prevent pressure injury ..." 08/17/2021 "Cleanse wound right shoulder with Anasept wound cleanser spray ... then apply Anasept wound gel cover with 4x4 and secure with border gauze daily every night shift for wound care- start date" Review of the TAR from 07/20/2021, to 08/17/2021, showed that facility staff signed that they: "performed daily head to toe skin assessment Q shift (twice daily), would notify MD/NP of any abnormalities and document the assessment and turned and repositioned the resident every two hours and as needed to prevent pressure injury ..." However, review of the Skin and Wound	L 052	The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 052	Continued From page 74 Evaluation V5.0 form dated 08/17/2021 showed the following: "... Stage- unstageable: obscured full thickness skin and tissue loss; 22. Location: right shoulder; In-house acquired; Exact Date- [left blank]; Wound Measurements= Area-7.8 cm, length 4.3 cm x width 2.4 cm x depth not applicable ...slough- 100%, ...Progress -New ...Notes: Resident seen on wound rounds, noted new pressure injury to right shoulder, wound is 100% slough covered. Periwound area has intact blister and redness ... Facility staff were signing in the medical record that they were assessing Resident #83's skin daily and turned and repositioned the resident every two hours. However, Resident #83 developed an in-house acquired pressure injury noted at an advanced stage (unstageable pressure injury to his right shoulder at the first observation and assessment). During a face-to-face interview conducted on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents." 3. Resident #73 was admitted to the facility on 03/11/2020 with multiple diagnoses that included: Chronic Respiratory Failure, Anoxic Brain	L 052	**E. Facility staff failed to ensure that sufficient nursing time was given to change Resident #76'scolostomy bag (a plastic bag attached to the abdomen that collects fecal matter from the digestive tract through an opening in the abdominal wall called a stoma...), when it was full, in accordance with the physician's order andprofessional scope and standards of practice.** 1. Corrective action for resident Resident #76's colostomy was changed/emptied at the time of the observation. Resident #76 is having her colostomy bag changed/emptied as prescribed and as needed. 2. Identify other residents An audit of other residents with colostomies did not reveal any other residents that were affected. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that resident's colostomy bags are being emptied/changed as prescribed. The Director of Nursing will be responsible for ensuring that residents are having their colostomy bags emptied/cleaned regularly. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of residents with colostomies to ensure that they are being emptied/cleaned as prescribed and as needed. The results will be	11/02/2021

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L 052	Continued From page 75 Damage and Chronic Kidney Disease. Review of the medical record revealed the following: 03/11/2020 [Braden Scale] - Resident #73 scored a "9" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries. 04/28/2020 [Physician Order]- "Weekly skin assessment and report any abnormality to the MD (medical doctor)/NP (nurse practitioner)" 04/28/2020 [Physician Order]-"Moisturize skin with hydroguard (skin lotion) every shift" 04/28/2020 [Physician Order]- "Turn and reposition q (every) two hours." 04/29/2020 [Physician Order]- "Administer bed bath or sponge bath to resident daily and as needed ..." 07/19/2020 [Braden Scale] - Resident #73 scored a "9" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries. 07/30/2020- [Physician Order] - "Apply skin prep to DTI (Deep Tissue Injury) left heel twice a day, monitor, and report any redness or drainage every day and night shift for wound care." 07/30/2020 [Physician Order] - Cleanse right heel wounds with Anesept spray (wound cleanser) pat dry then apply Anesept gel (antimicrobial skin gel)... off load both heels with pillows continuously every 12 hours ..." 08/18/2020 [Skin & Wound Evaluation]- "Left lateral malleolus ... Resident seen by wound care	L 052	reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 052	Continued From page 76 staff for weekly assessment. New Stage 4 pressure injury noted to left malleolus area has 0.5 cm (centimeters) area of slough also able to palpate bone in wound bed. Unit manager made aware ..." "08/18/2020 [Skin & Wound Evaluation] -"Right lateral malleolus ... Resident seen by wound care staff for weekly assessment. New unstageable pressure injury to right malleolus noted. wound is dry eschar, with no redness or drainage noted at edges ..." Review of all progress notes (such as, nursing, physician, dietary) from 07/01/2020 to 08/17/2020 lacked documented evidence that Resident #73 ' s Stage 4 Left Malleolus pressure injury and the Unstageable Right Malleolus pressure injury was observed by staff prior to the wound team ' s assessment on 08/18/2020. Review of the Treatment Administration Record (TAR) from 08/01/2020 to 08/18/2020 revealed that facility staff documented that Resident #73; received a bed or sponge during the day shift, bilateral heels were off loaded during the day and at night, skin was moisturized during the day, evening and night shifts, and was being turned and repositioned every two hours at 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM and 10:00 PM. Review of Resident #73's "CNA Activity of Daily Living (ADL) Notes" from 08/01/2021 to 08/18/2021 revealed that facility staff documented "No" to the question that asked, "Is there a new skin condition?" Review of the Admission MDS dated 03/18/2021	L 052	**F.Facility staff failed to ensure that sufficient nursing time was given to accurately reassess and evaluate the resident pain after administeringher pain medication. Residents' #56 and #87.** 1. Corrective action for resident Resident #56 is currently out of the facility, upon readmission the resident's orders for pain medication will be reviewed to ensure clear indicators for administration. The resident will also be assessed pre/post medication delivery. Resident #87 no longer resides in the facility. 2. Identify other residents An audit of other residents with orders for pain medications was completed and residents were assessed for indications and effectiveness. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that residents are given pain medication as ordered and assessed for indications and effectiveness of pain medication and administration as prescribed prior to wound care treatments. The Director of Nursing will be responsible for ensuring that residents are assessed for effectiveness of pain medication. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of 10% of residents receiving pain medication to ensure that the medication was given per physician orders and has been effective. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.	11/02/2021

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L 052	Continued From page 77 revealed that facility staff coded the following: In Section G (Functional Status), "bed mobility... total dependence... two+ (plus) persons physical assist ..." In Section H (Bowel and Bladder), "urinary continence ... bowel continence ... always incontinent ..." In Section M (Skin Conditions), " ... risk of pressure ulcers ...yes ..."; " ... resident has a pressure ulcer/injury, a scar over bony prominence, or a non-removable dressing/ device ...no ...", " ...is this resident at risk of developing pressure ulcers/injuries?... yes", " ... does this resident have one or more unhealed pressure ulcers/injuries?... no" Review of the Care Plan revealed the following: Focus: "Activities of Daily Living Self-care Performance Deficit" dated 03/11/2020 revealed several interventions including, "provide sponge bath when a full bath or shower cannot be tolerated ...bed mobility, and the resident is totally dependent on staff for repositioning and turning in bed every 2 hour." Focus: "Alteration in Neurological Status" dated 03/12/2020 revealed several interventions including "... skin inspections daily and report any findings to the nurse." Although the facility implemented approaches identified in the resident care plan (turn and reposition and inspect skin daily). Subsequently, Resident #73 developed an in-house acquired Stage 4 Left Malleolus pressure injury and a Unstageable Right Malleolus pressure on	L 052	The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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L 052

Continued From page 78

08/18/2020.

During a face-to-face interview conducted on 09/08/2021 at approximately at 9:35 AM, Employee #9 (Director of Wound Care) stated, "The wound team has educated the nursing staff multiple times on assessment, documenting and reporting of resident ' s skin. I have brought this issue of the nursing staff not documenting or making the wound team aware of skin issues at an early stage to the attention of the Director of Nursing and the Administrator."

4. Resident #62 was re-admitted to the facility on 07/31/2021. The medical record showed the resident had several diagnoses including: Dependency on Respirator [Ventilator], Tracheostomy, Diabetes Mellitus, Protein-Calorie Malnutrition, Stage 4 Left Calf Pressure Ulcer, Stage 4 Scapula Pressure Ulcer, Stage 4 Left Trochanter Pressure Ulcer, Stage 3 Left Heel Pressure Ulcer, Left Foot Deep Tissue Injury, and Surgical Sacral Wound.

During an observation on 08/24/2021 starting at 12:12 PM, the wound care team provided wound care for Resident #62's wounds for the left hip, left leg, back and sacrum.

Review of the medical record revealed the following:

05/07/2021 [Braden Scale] - Resident #62 scored a "10" indicating that the resident was at "very high risk" for developing pressure ulcers/injuries.

05/08/2021 [Physician Order] - Turn and reposition every 2hrs (hours) for comfort and to help prevent pressure injury every shift.

L 052 — Provider's Plan of Correction (Complete date: 11/02/2021)

G.Facility, staff failed to ensure that sufficientnursing time was given to have a resident evaluated by a psychiatrist, as ordered by the physician. Residents' #102.

1. Corrective action for resident

Resident #102 is currently being assessed for the effectiveness of their psycho tropic medications. They have also been evaluated by a psychiatrist.

2. Identify other residents

An audit of other residents on psychotropic medications and orders for psychiatric evaluations has been completed. Residents have been evaluated as needed and are being assessed for effectiveness of their psychotropic medications. There were no additional findings related to this citation.

3. Systemic changes

Nursing staff have been educated on the importance of ensuring that residents received ordered medical evaluations and are evaluated for the effectiveness of their medications. The Director of Social Services will be responsible for ensuring that residents are evaluated by the psychiatrist per physician orders and that the effectiveness of the psychotropic medications is assessed.

4. Monitor corrective actions

The Director of Social Services/Designee will complete weekly audits of Behavior Monitoring sheets of all residents on psychotropic medications to ensure that they are assessed for the effectiveness of their medications and that

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L 052	Continued From page 79 05/08/2021 at 4:15 AM (Nursing Admission Summary Note) - "Resident...admitted... at 7pm ...Resident has a sacral wound stage IV (4), (6cm (centimeters) X 5(cm) X 1 (cm) deep). Moderate amount of serosa (serosanguinous) drainage noted. (Left lower leg wound 0.6cm X 1.0cm). (Left buttock pressure 0.1cm)...with multiple scattered wound. Multiple scars noted to bilateral lower extremities. Old surgical sites to chest and abdomen." 05/09/2021 at 2:16 AM (Nursing Progress Note)- "Resident alert and responsive, 2nd day of readmission ...skin warm and dry to touch ...ADL and wound cares (sp) provided ... turn (sp) and reposition (sp) every two hours and as needed to prevent pressure ulcer ..." 05/10/2021 at 1:06 PM (Nursing Progress Note) - "Resident is alert and responsive, skin warm and dry to touch ...ADL care provided, turning, and repositioning every two hours as needed to prevent pressure ulcer (sp) ..." 05/10/2021 1:58 PM (Skin & Wound Evaluation)- "new, in-house acquired, Left calf, Stage 3 (Full-thickness skin loss), pressure(injury), length 3.2 cm (centimeters), width 2.7 cm, depth 0.1 cm, undermining not applicable, tunneling not applicable. wound bed 100% granulation -pink or red, exudate light, seropurulent ..." Review of the Treatment Administration Records for May 2021 revealed the following: Nursing staff signed their initials indicating that they had turned and repositioned Resident #62 every (2) hours from 05/08/2021 to 05/10/2021. Review of the Care Plans revealed the following:	L 052	they have been evaluated by a psychiatrist as ordered. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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Focus: "Skin Impairment related to Immobility" with am initial date of 05/07/2021, outlined multiple interventions including turn and reposition resident to prevent pressure injuries.

Review of the Minimum Data Set dated 04/21/2021 revealed, In section C (Cognitive Patterns), Brief Interview for Mental Status summary score was blank. In section G (Functional Status - Bed mobility) the resident was coded as a "4" indicating that the resident was totally dependent on the staff. The support section was left blank. In section M (Skin Condition), the resident was coded to having four (4) Stage 3 pressure ulcers, three (3) Stage 4 pressure ulcers, one (1) unstageable pressure ulcer and one (1) unstageable Deep Tissue Injury.

Although the facility implemented approaches identified in the resident care plan (turn and reposition). Subsequently, Resident #62 developed in-house acquired wound (Left Calf) Stage 3 pressure injury within 48 hours of his re-admission date of 05/08/2021.

During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #10 (Wound Team Nurse) stated that on 05/10/2021 she assessed Resident #62 ' s skin and observed an in-house acquired Stage #3 pressure injury on the resident ' s left calf.

During a face-to-face interview on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure

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injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents."

5. Resident #42 was re-admitted to the facility on 09/12/2020 with diagnoses that included Acute and Chronic Respiratory Failure, Type 2 Diabetes Mellitus, Tracheostomy, Gastrostomy, Hypertension, Contractures (Right and Left Elbow), and Pressure Ulcer Left Heel Stage 4.

According to the Quarterly MDS dated 06/30/2021 the resident was coded as "rarely/never understood" under Section C (Cognitive Patterns); Under Section G (Functional Status), G0400, the resident was coded as "total dependence" on staff for bed mobility, eating, toilet use, and personal hygiene; Functional Limitation in Range of Motion the resident was coded for "impairment to upper and lower extremities". Section M (Skin Conditions), the resident was coded as at risk for pressure ulcers and one (1) unhealed pressure ulcer.

According to the Braden Scale, Resident #42 was assessed and scored at a "9" indicating that she was "very high risk" for skin breakdown on 04/03/2021 and was assessed and scored at a "10" indicating "high risk" for skin breakdown on 07/03/2021.

Review of the care plan with the focus area, "Stage 4 pressure injury to left lateral malleolus" revealed the following interventions, "the resident needs assistance to turn/reposition at least every 2 hours, more often as needed or requested" dated 07/23/2021, "Follow facility

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policies/protocols for the prevention/treatment of skin breakdown" initiated 12/04/2020.

Review of the physician ' s orders revealed the following:

06/11/2021 "Cleanse left medial heel wound with Anasept wound cleanser spray ... every day and PRN (as needed). Please float heels continuously to prevent pressure every night shift for wound care"

09/13/2020 "Float heels while in bed with a pillow to prevent skin breakdown and pressure every shift (day, evening , night)"

09/13/2020 "Daily head to skin assessments per protocol every shift and as needed, and they would notify MD (medical doctor) for any abnormality every day and night shift"

05/30/2021 "Turn and reposition every 2 hours and as needed for relieving and redistribution"

Review of the Treatment Administration Record from 07/01/2021 to 07/14/2021 showed that facility staff signed that they: performed wound care to the resident ' s left heel, floated the resident ' s heels twice daily, performed head-to-toe notify MD (medical doctor) for any abnormality every day and night shift, and turned and repositioned the resident every two hours and as needed for reliving and retribution.

However, review of the Skin and Wound Evaluation V5.0 form dated 07/14/2021 showed the following:

"... Stage 4 full thickness and tissue loss...
Location: Left Lateral Malleolus (ankle) ...

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L 052	Continued From page 83 Acquired; In-house acquired... Exact Date-7/14/21; Wound Measurements= Area-2.5 cm, length 2.2cm x width 1.8 cm x 0.5 depth, undermining 1.0 cm; Wound bed -slough 100% of wound filled; exudate-light; type seropurulent; Notes: Resident seen by wound care team, noted development of new pressure injury to left lateral malleolus (sp). Wound is stage 4, full thickness with palpable bone in wound bed full description and pictures in PPC (point click care) ..." Facility staff were signing that they: conducted wound treatments to the residents left heel twice daily, were assessing the residents skin daily, floated the resident ' s heels twice daily, and turned and repositioned the resident every two hours. However, Resident #42 developed an in-house acquired pressure injury noted at an advanced stage (stage 4 pressure ulcer to the Left Lateral Malleolus). During a face-to-face interview conducted on 09/08/2021 at approximately 10:15 AM, Employee #9 (Director of Wound Care) was asked how do residents' wounds (pressure injuries) evolve to an advanced stage before staff observed them? Employee #9 stated, "I can't speak to why the (pressure injuries) are found at advanced stages. I speak up when we (wound team) see issues with a resident's skin. I know that over the last couple of months, I have been bringing up in our Performance Improvement Meetings that nursing staff is not bathing residents."	L 052		

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B.Facility staff failed to ensure that sufficient nursing time was given to provide adequate supervision to monitor the residents whereabout in and out of the facility for Resident #93 who left the facility without the staff knowledge.

Resident #93 was admitted to the facility on 01/07/2021 with diagnoses that included: Fracture of the Lower End of Right Tibia, Anemia, Unsteadiness on Feet, Weakness, Schizoaffective Disorder, and Bipolar Type.

According to the Quarterly Minimum Data Set (MDS) dated 07/16/2021 the resident's Brief Interview for Mental Status (BIMS) Score was "15" indicating that the resident was cognitively intact. In Section G (Functional Status), the resident was coded as requiring supervision and set up help only for bed mobility; he was coded as independent in transferring, eating, toilet use, personal hygiene, and dressing. He required set up help from staff with dressing, eating and personal hygiene. The resident was coded as having impairment to his lower extremities on both sides and was coded as using a wheelchair for mobility.

Review of the progress notes showed:

08/30/2021 at 4:28 AM "Upon change of shift round, resident was not in his room, off going nurse stated that the resident is in the facility and did not sign himself out, his dinner tray was in the room untouched. Usually resident goes to another floor to visit, but up to the end of the medication pass, resident did not come back to the floor, resident was call on his cell phone, the number showed up wrong number, R/R (responsible party) was also called no answer,

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message left on the answering service for them to call the unit, supervisor made aware and she was on the floor to assessed the situation, couple of phone calls was made to his family member by her without success, resident still out at this time."

08/30/2021 at 6:46 AM "Security informed this writer at 06:00 that the resident had just returned back to the facility. Resident arrived on the unit at 06:10 AM stated that he had a family emergency and one of his family came and took him home at 02:00 PM yesterday (Sunday, 8/29/21) and that he did not [have] time the time to sign himself out, supervisor made aware and she was on the unit to [assess] the situation, refused to be assess instead asking for his sleeping medication, staff will continue to monitor the resident status."

Review of the security camera footage on 08/31/2021 at 4:18 PM showed that the resident exited the building at 1:09 PM on 08/29/2021.

Review of the Treatment Administration Record for 08/29/2021 shows that facility staff signed that they were turning, and repositioning Resident #93 every two hours as needed from 12:00 AM to 8:00 PM (0000, 0200, 0400, 0600, 0800, 1000, 1200, 1400, 1600, 1800, 2000).

During a face-to-face interview with Resident #93 on 08/31/2021 at 10:00 AM he stated, "It was my fault." And made no other statements.

Review of the clinical record, facility staff were documenting that they were providing care to Resident #93 on 08/29/2021 from 1:00 PM to 8:00 PM. However, the resident was not in the facility. The facility's staff noticed that the resident did not eat his dinner, but they failed to check/verify Resident # 93's location in the

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building.

Subsequently, the resident was gone from the building for approximately seven (7) hours before facility staff discovered that the resident was no longer present in the building and began to search for him.

During a face-to-face interview on 09/01/2021 at 8:45 AM, Employee #2 reviewed the documentation and made no comments on about the findings.

C. Facility staff failed to ensure that sufficient nursing time was given to weigh a resident every 30 days as ordered and verify accurate weights were being obtained. Residents' #37 and #95.

Review of the facility's policy entitled, "Charting and Documentation" revised 07/2017, revealed, " ... Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate ..."

1. Facility staff failed to weigh Resident #37 every 30 days as ordered by the physician.

Resident #37 was re-admitted to the facility on 09/01/2020. The record showed resident had the following diagnoses: Anemia, Hypertension, Diabetes Mellitus, Hyperlipidemia, Cerebral Vascular Accident (CVA), Hemiplegia, Seizure Disorder, Depression, Schizophrenia, and Paranoid Personality Disorder.

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A review of the Quarterly Minimum Data Set (MDS) dated 08/12/2021 revealed the following: In Section C (Cognitive Patterns), Resident #37 had a Brief Interview for Mental Status (BIMS) Summary Score of "15", indicating intact cognition. In Section G (Functional Status), Resident #37 was coded as, "total dependence, one-person physical assist," for dressing, toilet use, and personal hygiene.

Review of the clinical record revealed the following:

09/08/2020 at 10:00 AM [physician order] -"Weekly weight one time a day every Tuesday."

07/13/2021 at 11:36 AM - recorded weight of 167.2 lbs. (pounds)

Review of the nursing progress notes and the Treatment Administration Record (TAR) dated from 07/14/2021 to 08/31/2021 lacked documented evidence that facility staff weighed Resident #37 weekly as ordered.

During a face-to-face interview on 09/01/2021 at 12:15 PM, Employee #2 (Director of Nursing/ Unit Manager) stated that residents' weights are documented in the TAR and progress notes.

2. Facility staff failed to ensure accurate weights were being documented for Resident #95.

Resident #95 was admitted to the facility on 01/19/2021 with multiple diagnoses that included: Encounter for Gastrostomy, Acute and Chronic Respiratory Failure, Restlessness and Agitation.

Review of the Quarterly MDS dated07/18/2021 revealed that facility staff coded the following:

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In Section C (Cognitive Patterns), the resident was coded as being severely cognitively impaired. In Section I (Active Diagnoses), the resident was coded for "Malnutrition (protein, calorie) ..."

Review of the physician's orders revealed:

05/21/2021 "Dietary consult as needed"

06/03/2021 "Monthly weight one time a day starting on the 3rd and ending on the 3rd every month ..."

Review of the facility documented weights for Resident #95 revealed:

"05/11/2021 156.0 Lbs (pounds), 05/12/2021 126.0 Lbs, 05/20/2021 129.0 Lbs, 05/21/2021 130.0 Lbs, 05/28/2021 156.4 Lbs, 06/10/2021 150.6 Lbs, 07/20/2021 146.2 Lbs".

Review of the care plan with a focus area of: "[Resident's name] has nutritional problem" with a revision date of 05/16/2021 revealed the following interventions " ... monitor/record/report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of malnutrition ... significant weight loss ..."

Review of the progress notes revealed:

05/27/2021 at 12:15 PM (Nutrition/Dietary Note) "Spoke to son about current nutrition and weight status. Writer [Registered Dietician] discussed plan for GT (gastrostomy tube) removal ..."

06/16/2021 at 12:43 PM (Nutrition/Dietary Note) " ... PO (by mouth) intake S/p (status post) PEG (percutaneous endoscopic gastrostomy) removal

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L 052	Continued From page 89 ... PO intake: 50-100% of meals - requires assistance with meals ... Current BW (body weight): 150.6 (pounds) - 6/10, 156 (pounds) ... Will continue to monitor PO intake/TF (tube feed) tolerance, weights ..." Although Employee #28 (Registered Dietician) reviewed and recorded clinical notes regarding the residents nutritional status, there was no evidence that she reviewed the weights to determine their accuracy or if the resident sustained a significant weight loss. During a face-to-face interview conducted on 08/30/2021 at 10:08 AM, when asked about the weights that were documented on 05/12/2021, 05/20/2021 and 05/21/2021, Employee #28 stated that the weights on those days in May [2021] were not accurate. D. Facility staff failed to ensure that sufficient nursing time was given to provide respiratory care consistent with the professional standards of practice as evidenced by failure to ensure one (1) resident receiving oxygen therapy had physician's orders to direct the amount of oxygen to be delivered to the resident. Resident #21. Resident #21 was readmitted to the facility on 06/29/2021, with multiple diagnoses that included: Respiratory Failure, Encounter for Attention to Tracheostomy and Degenerative Joint Disease. Review of the Admission MDS dated 07/07/2021 revealed that facility staff coded the following:	L 052		

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In Section I (Active Diagnoses), "dependence supplemental oxygen ...". In Section O (Special Treatments, Procedures and Programs), Oxygen, "Yes".

On 08/2520/2021 at approximately 09:45 AM the resident was observed in bed with a tracheostomy and oxygen in place.

Review of the physician's orders revealed no documented evidence of oxygen orders in place to specify how much oxygen Resident #21 was required to be on.

During a face-to-face interview conducted on 08/30/2021 at 9:42 AM, Employee #26 (Respiratory Therapist) stated, "He [Resident #21] should have an oxygen order. I will message the pulmonologist now."

E. Facility staff failed to ensure that sufficient nursing time was given to change Resident #76's colostomy bag (a plastic bag attached to the abdomen that collects fecal matter from the digestive tract through an opening in the abdominal wall called a stoma...), when it was full, in accordance with the physician's order and professional scope and standards of practice.

According to The American Cancer Society,"...Change the pouching system regularly to avoid leaks and skin irritation. It's important to have a regular schedule for changing your pouch. Don't wait for leaks or other signs of problems... There may be less bowel activity at certain times

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in the day. It's easiest to change the pouching system during these times. You may find that early morning before you eat or drink is best..."

https://www.cancer.org/treatment/treatments-and-side-effects/treatment-types/surgery/ostomies/colostomy/management.html

Resident #76 was admitted to the facility on 03/27/2020 with multiple diagnoses including: Colostomy, Gastroesophageal Reflux Disease (GERD), and Generalized Muscle Weakness.

Review of the Quarterly Minimum Data Set (MDS) dated 06/29/2021 revealed the facility staff coded Resident #76 as followed:

In Section C (Cognitive Patterns) the resident had a Brief Interview for Mental Status (BIMS) Summary Score of "12" indicating she is mildly cognitively impaired. In Section G (Functional Status), facility staff coded "totally dependent on staff for dressing, toilet use, and personal hygiene" and required "one-person physical assist". In Section H (Bowel and Bladder), Appliance, facility staff coded "ostomy".

Review of a physician's order dated 03/28/2020 directed, "Colostomy care every shift as needed."

During an observation and face-to-face interview on 08/23/2021 at 6:53 AM, Resident #76 stated that two days ago she waited a long time for staff to change her colostomy bag. She further stated, "It (colostomy bag) got so full that it started to leak. I'm afraid to leave my room to participate in activities because my bag (colostomy bag) might leak." The resident then attempted to pull her over-the-bed table close to her body, but she couldn't because the colostomy bag was full.

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On further observation, at 6:54 AM, Resident #76 pressed the call light in order to tell the nurse her colostomy bag is full and in need of changing. At 7:05 AM (11 minutes later), Employee #44 (Registered Nurse) came in the room to see what the resident wanted. Resident #76 stated to Employee #44 that she needed her colostomy bag changed. Employee #44 then stated to the resident and surveyor, "I did not change the bag (colostomy) because I was looking for my scissors, they were on the medication cart and now they are not." Employee #44 then left the resident's room and came back at 7:15 AM to change the resident's bag. Employee #44 pulled back the covers to assess the colostomy bag and stated, "It is mostly air, but I will change it anyway."

There was no evidence that facility staff provided the necessary care and treatment to Resident #76 when her colostomy bag was full and in need of changing.

F.Facility staff failed to ensure that sufficient nursing time was given to accurately reassess and evaluate the resident pain after administering her pain medication. Residents' #56 and #87.

Review of the facility's policy entitled: "Pain Assessment and Management" revised March 2015, documented:

"Assessing Pain
1. During the comprehensive pain assessment

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[staff is to] gather the following information as indicated from the resident (or legal representative):

a. History of pain (as measured on a standardized pain scale);

b. Characteristics of pain:
(1) Intensity of pain (as measured on a standardized pain scale);
(2) Descriptors of pain;
(3) Pattern of pain (e.g. constant or intermittent);
(4) Location and radiation of pain; and
(5) Frequency, timing and duration of pain.

c. Impact of pain on quality of life;
d. Factors that precipitate or exacerbate pain;
e. Factors and strategies to reduce pain; and
f. Symptoms that accompany pain (e.g., nausea, anxiety)...

Implementing Pain Management Strategies:
...6. Implement the medication regimen as ordered, carefully documenting the results of the interventions.

Monitoring and Modifying Approaches:
---2. Monitor the following factors to determine if the resident ' s pain is being adequately controlled:

a. The resident's response to interventions and level of comfort over time;
b. The status of the underlying cause(s) of pain, if identified previously; and
c. The presence of adverse consequences to treatment."

According to the facility's Pain Assessment and Management policy last reviewed May 2016 the

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pain scale rating is as follows: 0= none; 1-3= mild; 4-6=moderate, 7-10=severe

1. Facility staff failed to reassess Resident #56's pain level after the administration of ordered pain medication.

Resident #56 was admitted to the facility on 06/01/2021 with the following diagnoses: Opioid Dependence, Peripheral Vascular Disease (PVD), Diabetes Mellitus, Acquired Absence of Right Foot, Cirrhosis, Chronic Pancreatitis, Chronic Viral Hepatitis C, and Depression.

A review of Resident #56's clinical record revealed the following physician's orders:

06/01/2021 "assessment every shift and prn (as needed)

06/01/2021 "Methadone (opioid pain reliever) HCL (hydrochloride) tablet 5 mg (milligram), " Give one tablet by mouth every 12 hours as needed for Pain 4-6 (Moderate)."

07/08/2021 for Tramadol (opioid pain reliever) HCL tablet 50 mg" Give 1 tablet by mouth every 6 hours as needed for pain

09/02/2021 for Oxycodone (opioid pain reliever) HCL tablet 5 mg Give 1 tablet by mouth two times a day for pain

Review of the Medication Administration Record for September 2021 showed:

On 08/12/2021 and 08/15/2021 staff administered Methadone for a pain level of 3 out of 10 and on 8/21/21 staff administered Methadone for a pain

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L 052	Continued From page 95 level of 0 out of 10. On 09/11/2021 facility staff administered Tramadol at 9:17 AM for a pain level 4 out of 10 and again at 12:00 PM for a pain level of 5 out of 10. The tramadol was administered approximately 3 hours apart, however the physician's order dated 07/08/2021 directs staff to give Tramadol every 6 hours as needed for pain. On 09/11/2021 and 09/12/2021 at 10:00 AM, staff administered Oxycodone HCL tablet 5 mg for pain level 0/10 On 09/12/2021 staff administered Tramadol at 9:00 AM for a pain level 5 out of 10 and again at 9:45 AM for a pain level of 4 out of 10. Continued review of the Medication Administration Record for September 2021 showed Resident #56 was to receive Methadone 5 mg every 12 hours for pain 4-6 (moderate); however there were no pain level parameters listed to direct staff when to administer the Tramadol 50 mg, and Oxycodone 5 mg, for example for mild, moderate or severe pain. Lastly, review of Resident #56's Medication Administration Record for August and September 2021 lacked documented evidence that facility staff performed a post pain assessment to determine if the pain medication administered to the resident was effective and what was the resident's pain level post medication administration. During a face-to-face interview conducted on 08/26/2021 at 9:22 AM, Employee #23 (Unit Manager) stated that pain assessments should be performed before and after pain medication is	L 052		

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administered to residents. She acknowledged that pain was not consistently noted the progress notes nor on the medication administration record, for Resident #56. She reported that nurses cannot e-sign that a pain medication was administered without performing a post assessment, however she was not able to provide documented evidence that post assessments for pain were done for Resident #56.

2. The facility's staff failed to administer pain medication for Resident #87 prior to providing wound care.

Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Cerebral Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, Obesity, Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer.

During an observation on 08/24/2021 at approximately 11:20 AM, Employee #16 (Registered Nurse) was administering medication to Resident #87 via the resident's gastrostomy tube. When asked what medication she was administering, the employee stated that she was administering pain medication before she provides wound care for the resident.

Observation of the resident's wound dressings to her right leg and sacral area revealed they were clean, dry and intact. The dressings were also signed and dated by Employee #10 (Wound

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Team Nurse) "08/24/2021 at 7:00 am to 7:00 PM" indicating that wound care had been provided prior to the administration of the pain medications by Employee #16.

Review of physician's orders revealed the following:

05/10/2021- "Norco (opioid pain reliever) Tablet 5-325 milligram (Hydrocodone-Acetaminophen) give 1 tablet via PEG (percutaneous endoscopic gastrostomy) tube every day shift ...prior to wound care for pain."

07/23/2021 - " ...Cleanse (sacral and left calf) wound with Dankin's solution then apply moist to dry dankin ' s solution dressing covering with abd (abdominal) pad and secure with coversite [stratasorb] dressing every 12 hours and PRN (as needed)."

Review of the Narcotic Count Sheet for Hydrocodone/Acetaminophen revealed that Employee #16 signed indicating that she had administered the medication on 08/24/2021 at 11:20 AM.

There is no evidence that facility staff administered pain medication to Resident #87 in accordance with the physician's order.

During a face-to-face interview on 08/24/2021 at approximately 11:25 AM, Employee #16 stated that she was unaware that Resident #87's wound care had been provided. She then stated that she administered the pain medication (Hydrocodone-Acetaminophen) in error.

During a face-to-face interview on 08/24/2021 at approximately 11:40 AM, Employee #10 (Wound

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L 052	Continued From page 98 Team Nurse) stated that she had provided wound care to the resident around 8:00 AM or 9:00 AM because she was told by Employee #14 (Unit Manager) Resident #87 had received pain medication. During a face-to-face interview on 08/24/2021 at approximately 11:41 AM, Employee #14 (Unit Manger) stated that she misunderstood Employee #10. Employee 14 then stated that Resident #87 did not receive pain medication prior to wound care on 08/24/2021. G.Facility, staff failed to ensure that sufficient nursing time was given to have a resident evaluated by a psychiatrist, as ordered by the physician. Residents' #102. Resident #102 was readmitted to the facility on 06/25/2021 with multiple diagnoses including: Multiple Fractures of Ribs, Acute Chronic Respiratory Failure with Hypoxia, Unspecified Fracture of lower end of right Femur, and Pressure Ulcer of sacral region. Review of the physician's orders revealed the following: 06/26/2021- "Psych consult ..." 08/07/2021- "Psych consult one time only for agitation and refusal of medication ..." 08/9/2021- "Psych consult one time only for agitation and refusal of medication ... " 08/10/2021- "Psych consult one time only for agitation ...- 08/26/2021-"Psych Consult asap (as soon as	L 052		

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L 052	Continued From page 99 possible) and PRN ..." Review of the Quarterly Minimum Data Set (MDS) dated 08/17/2021 revealed the following: In Section C (Brief Interview for Mental Status) - the resident was given a score of "15: indicating that the resident intact cognitively. In Section D (Mood) - the resident was coded as a "01" indicating minimal depression. In Section E (Rejection of Care-Presence & Frequency) the resident was coded as "2" indicating this behavior occurred 4 to 6 days but less than daily. Review of the medical record revealed that there was no documented evidence from 06/26/2021 to 09/16/2021 that Resident #102 was evaluated/assessed by a mental health provider. During a face-to-face interview conducted on 09/16/2021 at 3:15 PM, Employee #14 (Unit Manager) stated, "I' m not sure if a psych (psychiatric) consult (evaluation/assessment) was done."	L 052		
L 056	3211.5 Nursing Facilities Beginning January 1, 2012, each facility shall provide a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day, of which at least six tenths (0.6) hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to any coverage required by subsection 3211.4.	L 056	**L 056** **This Statute is not met as evidenced by: Based on record review and staff interview, facility staff failed to ensure a minimum dailyaverage of four and one tenth (4.1) hours ofdirect nursing care per resident.**	12/03/2021

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This Statute is not met as evidenced by:
Based on record review and staff interview, facility staff failed to ensure a minimum daily average of four and one tenth (4.1) hours of direct nursing care per residnent.

The findings included:

Review of the facility's staffing revealed that for 19 out 32 days from 07/25/2021 to 08/31/2021, the direct nursing care per resident was below the regulatory requirements of 4.1.

July 25, 2021- 2.5
July 26, 2021- 3.0
July 27, 2021- 2.4
July 28, 2021- 2.7
July 29, 2021- 3.3
July 30, 2021- 2.9
August 01, 2021- 3.9
August 02, 2021- 3.3
August 03, 2021- 3.9
August 06, 2021- 3.3
August 10, 2021- 3.9
August 11, 2021- 3.6
August 13, 2021- 3.8
August 15, 2021- 3.7
August 18, 2021- 3.4
August 24, 2021- 3.2
August 25, 2021- 3.0
August 26, 2021- 4.0
August 29, 2021- 3.3
August 30, 2021- 3.6

During a face-to-face interview with Employee #1 (Administrator) on 09/08/2021 at approximately 8:45 AM, he acknowledged the finding.

1. Corrective action for resident

The staffing coordinator and Director of Nursing have been in-serviced on how to calculate the direct nursing care hours to ensure at least 4.1 hours of direct nursing care per resident per day and at least 0.6 hours of those hours in RN hours per patient per day.

2. Identify other residents

All residents had the potential to be affected by this alleged practice.

3. Systemic changes

The Director of Nursing will review the nursing schedule prior to each weekend and holiday to ensure enough nursing coverage is available to meet the 4.1 hours of direct nursing care required. In addition, the nursing leadership will be on-call to come in and work in the event staff call outs cause the direct care staffing to fall below 4.1 hours per resident per resident per day. The Administrator will be contacted by the Director of Nursing for additional resources as needed to ensure appropriate staffing ratios.

4. Monitor corrective actions

The Director of Nursing/Designee will complete audits of schedules as worked weekly for compliance. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

5. Date correction action completed

The QAPI Committee is responsible for the on-going monitoring for compliance.
The facility's date of alleged compliance is December 3, 2021.

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L 064	Continued From page 101	L 064	**L 064**	11/02/2021
L 064	3213.1 Nursing Facilities The facility shall have a restorative nursing care program to assist in maintaining the highest practicable level of physical, mental and psychosocial well-being of each resident. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 44 sampled residents, the facility ' s staff failed to ensure residents received treatment and care in accordance with professional standards of practice and in accordance with residents ' choices as evidenced by failure to ensure Resident #100 received restorative nursing for contracture management. The findings include: Resident #100 was admitted to the facility on 04/26/2021, with multiple diagnoses ' that included Cerebral Palsy, Quadriplegia, Neuralgia and Neuritis. On 08/24/2021 at approximately 12:30 PM Resident #100, was observed having his mittens removed by staff and the writer observed that both Residents hands were closed tightly and Resident# 100 ' s limbs appear stiff and staff had difficulty moving residents arms. According to the Quarterly Minimum Data Set (MDS) dated 08/02/2021, Resident#100 received Physical therapy that started on 04/27/2021 and ended on 06/29/2021. In section G (Functional Status) G0400, facility staff coded resident as a "1" for upper extremity meaning there is impairment on one side and facility staff coded the resident as a "2" for lower extremity meaning	L 064	**The facility shall have a restorative nursing careprogram to assist in maintaining the highest practicable level of physical, mental and psychosocial well-being of each resident.** 1. Corrective action for resident Resident #100 was assessed by therapy and deemed inappropriate for the restorative program. 2. Identify other residents An observation audit of other residents was completed and all residents deemed appropriate for the restorative program and/or device management have been seen. 3. Systemic changes Nursing/Rehabilitation staff have been educated on the new restorative program. The Rehabilitation Director in conjunction with the Director of Nursing will be responsible for ensuring that residents receive quality care. 4. Monitor corrective actions The Rehabilitation Director /Designee will complete weekly audits of residents on the restorative program to ensure that ordered devices are being used per physician orders. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.	

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L 064	Continued From page 102 there is impairment on both sides. Review of the medical record revealed a documents entitled "PT (Physical Therapy) and OT (Occupational Therapy) Progress & Discharge Summary" dated 06/24/2021 for OT and 06/29/2021 for PT, which stipulated that resident #100 was to receive Restorative Nursing services for contracture management upon discharge from OT and PT case load. During a face-to-face interview conducted on 08/31/2021 at 10:50 AM with Employee #13 (Director of Rehabilitation Services) she stated " Resident #100 is not on case load and had been discharged (06/29/2021) to restorative nursing program. During a face-to-face interview conducted on 08/31/2021 at 11:37 AM with Employee # 2 (Director of Nursing) she stated "Currently we do not have one [Restorative Nursing]"	L 064	The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	
L 065	3213.2 Nursing Facilities Each nursing employee shall provide restorative nursing in his or her daily care of residents, which shall include the following: (a) Maintaining good body alignment and proper positioning of bedridden residents; (b) Encouraging and assisting bedridden residents or those residents that are confined to a chair to change position at least every two (2) hours or more often as the resident's condition warrants, day and night, to stimulate circulation; prevent bed sores, pressure ulcers and deformities; and to promote the healing of pressure ulcers;	L 065	**L 065** **Each nursing employee shall provide restorativenursing in his or her daily care of residents.** 1. Corrective action for resident Resident #48 has been assessed by therapy and deemed not appropriate for restorative care at this time. We have an active Restorative program. 2. Identify other residents An audit of all current residents was conducted to determine if restorative care and/or orthotics	11/02/2021

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L 065	Continued From page 103 (c) Encouraging residents to be active and out of bed for reasonable periods of time, except whencontraindicated by physician's orders; (d) Encouraging residents to be independent in activities of daily living by teaching and explaining the importance of self-care, ensuring and assisting with transfer and ambulating activities, by allowing sufficient time for task completion by the residents, and by encouraging and honoring resident's choices; (e) Assisting residents to adjust to their condition and to their use of prosthetic devices; (f) Achieving good body alignment and balance for residents who use mechanical supports, which are properly designed and applied under the supervision of a licensed nurse; (g) Identifying residents who would benefit from a bowel and bladder training program and initiating such a program to decrease incontinence and unnecessary use of catheters; and (h) Assessing the nature, causes and extent of behavioral disorientation difficulty and implementing appropriate strategies and practices to improve the same. This Statute is not met as evidenced by: Based on observation, record review and staff interview for one (1) of 44, sampled residents, facility staff failed to implement the use of orthotics to prevent decrease in range of motion and mobility. Resident #48	L 065	were needed. Residents were picked up on the restorative case load and orthotics were ordered if indicated. There were no additional findings related to this citation. 3. Systemic changes Nursing and Administrative staff have been educated on the importance of ensuring that residents receive appropriate restorative care. The Director of Rehabilitation will be responsible for maintaining the restorative program with assistance from the Director of Nursing. The IDT team will refer residents to therapy for the restorative program as needed. 4. Monitor corrective actions The Director of Rehabilitation/Designee will complete weekly audits of 10% residents to ensure that ordered orthotics are being used appropriately. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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The findings include:

Resident #48 was admitted to the facility on 04/19/2019, with multiple diagnoses including: Paraplegia, Muscle Weakness, Other Muscle Spasm, Pain Unspecified, Aphasia and Respiratory Failure.

Resident #48 was observed on 08/23/2021 at approximately 9:05 AM receiving care from Employee #43 (Licensed Practical Nurse) and it was noted that Resident #48's hands were tightly clasped in a fist like position and residents arms were stiff and difficult for staff to move.

Review of Resident #48's Quarterly Minimum Data Set (MDS) dated 06/13/2021, revealed: In Section C (Cognitive Patterns) C0100 facility staff coded resident as a "0" meaning resident is "rarely/never understood". In Section G (Functional Status) G0110 facility staff coded resident a "4" for bed mobility meaning resident is totally dependent on staff to perform this function every time during a seven day period. In Section G (Functional Limitation Range of Motion) G0400 facility staff coded resident as a "0" for Upper extremity meaning no impairment and coded resident a "2" for lower extremity meaning impairment to both sides. In Section O (Special Treatments, Procedures, and Programs), under "Restorative nursing programs" for "Range of Motion (passive), Range of motion (active) and Splint Brace assistance", facility staff coded all three as "0" meaning the activities were not performed.

Review of the Comprehensive Care Plan revealed with a focus area of: "[Resident ' s name] has limited physical mobility r/t (related to) Contractures of the bilateral hand and legs ..."

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L 065	Continued From page 105 revised on 02/07/2019 had multiple interventions including: "Apply roll towel to bilateral hands at all times remove every 2 hours for hygiene and skin check ..." Review of nursing progress noted and Treatment Administration Record dated from 07/01/2021 to 08/22/2021, lacked documented evidence that staff applied a rolled towel to both hands the resident's hands. During a face-to-face interview on 08/31/2021 at 11:30 AM, Employee #13 (Director of Rehabilitation) stated "The resident (Resident #48) was discharged to restorative nursing (staff that applies rolled towels for hands and splints)". During a face-to-face interview on 08/31/2021 at 11:37 AM, Employee #2 (Director of Nursing) "Currently we do not have one [Restorative Nursing]."	L 065		
L 080	3216.1 Nursing Facilities Each resident has the right to be free from physical and chemical restraints. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 44 sampled residents, facility staff failed to ensure that one resident was free from a physical restraint. Resident #95. The findings include: Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Cerebral Infarct due to Embolism of Left Middle Cerebral Artery, Restlessness and Agitation,	L 080	**L 080** **Each resident has the right to be free fromphysical and chemical restraints.** 1. Corrective action for resident Resident #95 has a restraint for their safety that is being used appropriately. 2. Identify other residents An audit of all residents with restraints did not reveal any residents whose restraints were not being used appropriately. There were no additional findings related to this citation.	11/02/2021

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L 080	Continued From page 106 Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy. Review of the facility's policy, "Use of Restraints" with a revision date of 04/2017 revealed, " ... Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted ..." Review of a facility reported incident (FRI) on 01/27/2021 documented, " ... During rounds on 1-27-2021 her (Resident #95) mitten was found tied to the rail. It was immediately released, and the patient was assessed ...Investigation is ongoing ..." Review of Resident #95's Admission Minimum Data Set)dated 01/26/2021, revealed that facility staff coded the following: In Section C (Cognitive Patterns), "Severely impaired" In Section E (Behavioral Symptoms), " ... Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) ... Behavior of this type occurred 1 to 3 days" In Section G (Functional Status), "Bed mobility ... total dependence, one-person physical assist" In Section P (Restraint), "Limb restraint [hand mitten] ...Used daily" Review of the physician's orders revealed the following: 01/19/2021- "Assess left wrist restraint q (every) 2 hours and document any findings every 2 hours"	L 080	3. Systemic changes Nursing staff have been educated on the importance of ensuring that restraints are used appropriately. The Director of Nursing will be responsible for ensuring that residents are not inappropriately restrained. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of all residents with orders for restraints to ensure that no restraints are being used inappropriately. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	

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01/19/2021- "Keep left wrist restraint in place to prevent patient from pulling on her trach (tracheostomy) or G (gastrostomy) - Tube q shift"

Review of the progress notes revealed:

01/27/2021 at 1:18 PM (Administrator note) "[Resident's name] is a 60 year old resident... who was admitted on 1-19-2021. During rounds on 1-27-2021 her mitten was found tied to the rail. It was immediately released and patient was assessed and not found to be in distress, pain or fearful. Resident's physician, RP (representative) and appropriate agencies were notified. House wide sweep conducted no other residents were found to have an inappropriate restraint. Investigation is ongoing. Son was satisfied and we told him we will be in communication with the conclusion."

Review of the facility's investigation notes and documents on 08/31/2021 revealed that only six (6) staff members were interviewed as part of the investigation. There was no documented evidence of interviews from the respiratory therapist who provided Resident #95 with tracheostomy care or from the environmental staff who cleaned Resident #95's room.

It was also noted that two staff members answered "no" when asked, "Do you know the abuse reporting policy and procedure" as part of the investigation's interview questions.

There was no documented evidence that the investigator(s) followed up with those staff members or is there documented evidence that any additional training/education was provided on

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restraints or the facility's abuse reporting policy and procedure.

Employee #1 (Administrator) acknowledged that Resident #95 was physically tied to the bedrail however, he did not substantiate that abuse occurred.

During a face-to-face interview conducted on 08/31/2021 at 10:54 AM, Employee #4 (Speech and Language Pathologist) stated, "The resident is nonverbal with right hemiparesis- pretty close to paralyses. Left side is intact. She had an order for left [hand] mitten. I walked into the room (on 01/27/2021) and noticed the straps to the mitten were wrapped around and tied to the upper bed rail, fully restricting her (Resident #95) movement of the left hand. I immediately removed the restraint, made the nurse aware and educated the nurse that the mitten was not to be used as a restraint. I then reported the incident to my supervisor and the administrator."

During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #2 (Director of Nursing) stated, "Mittens are used for residents who are a danger to themselves. After the incident, we interviewed the staff, assessed the resident and did audits of the other residents in the facility with hand mittens. We did not find any other residents with mittens tied to the bedrail."

During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #1 (Administrator) stated, "We couldn't substantiate the allegation. Based on the staff interviews, we could not determine who tied the resident to the bed rail. It could have been a staff, contractor or family member. We audited the facility and did not find any other resident with hand mittens tied

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L 080	Continued From page 109 to the bed." It should be noted that a review of facility's visitation log on 08/31/2021 at 10:00 AM revealed that Resident #95 did not have any visitors on 01/26/2021 or 01/27/2021.	L 080		
L 091	3217.6 Nursing Facilities The Infection Control Committee shall ensure that infection control policies and procedures are implemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter. This Statute is not met as evidenced by: Based on observation, record review, and interview, for three (3) of 44 sampled residents, the facility's staff failed to maintain Infection Control Practices when: preparing, serving, and distributing foods under sanitary conditions, as evidenced by using a cooling fan in the kitchen; while providing wound care for one (1) resident, administering medications to one (1) resident; and not sanitizing their hands before entering a resident's room to provide care. (Residents' #87 #47 and #100). The findings include: 1.Facility staff failed to prepare, serve, and distribute foods under sanitary conditions, as evidenced by a cooling fan that was in use, in the kitchen. During a walkthrough of dietary services on 08/23/2021, at approximately 6:45 AM, three cooling fans were being used in the food	L 091	**L 091** **The Infection Control Committee shall ensure that infection control policies and procedures areimplemented and shall ensure that environmental services, including housekeeping, pest control, laundry, and linen supply are in accordance with the requirements of this chapter.** 1. Corrective action for resident The cooling fan has been removed from the kitchen. The air handler is being addressed. The architects are preparing plans to be submitted for permitting prior to beginning project. Resident #87 no longer resides in the facility. Residents #47 and #100 have been observed receiving medications and patient care with proper infection control practices. The batteries in the soap dispenser in room 337 have been replaced. Random room audits have not yielded any soiled linen on clean surfaces. Audits of rooms with enhanced barrier precautions are being conducted. Staff #20, #36, #33, #34, #23, and #47 were educated on proper infection control and prevention practices.	11/02/2021

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preparation area. The temperature in the main kitchen at the time of the observation was 86 degrees Fahrenheit.

During a face-to-face interview with Employee #1 (Administrator) and Employee # 37, Employee #1 stated "The air is not sufficient in the kitchen. The air handler that services the kitchen, 2 West and 3 West is not working. The air handler has been down prior to 5/25/2021".

This deficient practice could potentially cause dust and/or foreign substances to spread through the kitchen and contaminate food items.

These observations were acknowledged by Employee #46 on September 1, 2021, at approximately 3:00 PM.

2.Employee #20 failed to maintain Infection Control Practices while providing wound care for Resident #87.

Review of the Wound Care Policy with a revision date of October 2010 instructed staff to: place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites ...loosen tape and remove dressing ...discard into appropriate receptacle. wash and dry your hands thoroughly. put on gloves ...

Resident #87 was re-admitted to the facility on 02/26/2021. The medical record showed the resident had several diagnoses including Stage 4 Sacral Pressure Ulcer, Stage 4 Left Ear Pressure Ulcer, Stage 4 Right Calf Pressure Ulcer Unstageable Right Heel Pressure Ulcer, and a Stage 2 Left Heel Pressure Ulcer, Cerebral

2. Identify other residents

An initial audit of infection control practices was completed. All residents have the potential to be affected. There were no additional findings related to this citation.

3. Systemic changes

Staff have been educated on the importance of ensuring that they follow appropriate infection control practices (including but not limited to hand hygiene, enhanced barrier precautions, proper use of PPE, wound care, and medication administration). Policies and procedures were reviewed and updated. The Infection Preventionist will be responsible for ensuring that staff utilize proper infection control and prevention practices.

4. Monitor corrective actions

The Infection Preventionist/Designee will complete random daily audits on each unit (on all shifts) of staff to ensure that proper infection control and prevention practices are being used throughout the facility across all disciplines. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations.

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is November 2, 2021.

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Vascular Accident, Dependency on Respirator [Ventilator], Tracheostomy, Gastrostomy, and Obesity.

Review of physician order dated 07/23/2021 directed, " ...cleanse wound with Dankin's solution, then apply moist to dry Dankin's solution dressing, cover with abd (abdominal) pad and secure with cover site [Stratasorb] dressing every 12 hours [and] prn (as needed)."

During an observation on 08/25/2021 starting at 3:30 PM, Employee # 20 (Registered Nurse) failed to maintain Infection Control Practices while providing wound care for Resident #87, as evidenced below:

1st -While setting up the clean field with wound care supplies, the employee removed sterile 4X4's (used internally in the sacral wound) from the packaging and placed them on the clean field set up on the bedside table.

2nd - After removing the wound packing including 4X4's from the resident's sacral wound (Stage #4 pressure wound), Employee #20 placed the soiled packing on an incontinent pad that she set at the foot of the resident's bed.

3rd - The employee then provided incontinent (bowel) care. However, she failed to recover the resident's sacral wound before providing incontinent care.

4th- The employee placed all dirty supplies used to provide incontinent care on an incontinent brief at the foot of Resident #87's bed. Employee #20 then removed her gloves but failed to perform hand hygiene before putting on a new pair of gloves.

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5th -Employee #20 failed to remove and discard the dirty material (dressing gauze and supplies used to provide incontinent care) at the foot of the resident's bed before providing wound care to Resident #87's Stage 4 sacral wound.

6th - Additionally, Employee #20 failed to place a clean field under the resident's sacral area before providing wound care. The employee provided wound care on top of a clean draw sheet.

During a face-to-face interview on 08/25/21 at approximately 4:00 PM, Employee #20 stated that she should have performed hand hygiene after removing her gloves when she provided incontinent care. The employee also said that she should have discarded the dirty supplies at the foot of the resident's bed before providing wound care.

3.Employee #36 failed to maintain Infections Control Standards of Practice when administering medications for Resident #47.

Review of the Administering Medication policy with a revised date of December 2012 instructed staff to "... follow established facility infection control procedures (e.g ... antiseptic technique ...) for the administration of medications, as applicable."

During an observation on 08/23/2021 starting at 9:28 AM, Employee #36 (RN) failed to maintain Infection Control Standards of Practice while administering Resident #47 ' s medications, as evidenced below:

The employee removed the resident's 10 AM

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medication packets from the medication cart, placed them on top the "Soiled Clothes Hamper" that was in the resident ' s room. Employee also placed the 30cc (cubic centimeters) cup, a straw and a cup of water on top of the "dirty clothes hamper". Employee #36 opened the medications packets one at a time and administered them.

While administering the resident ' s medications, Employee #36 was observed wearing gloves and touching the top of the "Solied Clothes Hamper" multiple times. The employee was then observed picking up the straw off the "dirty clothes hamper" and removing all the paper covering. Employee #36 was also observed touching the straw while mixing the Miralax and water. When the employee attempted to walk towards the resident to administer the Miralax, the state surveyor asked the employee to step out the room and speak with her in the hallway.

It should be noted that Resident #47 ' s room door had signage from the Center for Disease Prevention and Control (CDC) indicating that the resident was on Enhanced Barrier Precautions (are intended to provide an approach for gown/glove use that is based on resident risk factors and type of care, rather than based on MDRO (multidrug-resistant organism) status, especially for residents at risk for acquisition (i.e., presence of indwelling medical devices or wounds).

https://www.cdc.gov/hai/containment/PPE-Nursin g-Homes.html

Additionally, the unit had six (6) residents with Candia Aureus (classified by CDC as a MDRO).

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L 091	Continued From page 114 Resident #47 was admitted to the facility on 04/12/2021. The medical record revealed the resident had the following diagnoses Respiratory Failure with Hypoxia, Tracheostomy, Dysphonia, Kidney Disease and Anemia. Review of the physician's orders revealed the following: Review of the August 2021 Medication Adminstration Record revealed Employee #36 administered the following medication during the previously mentioned observation. Polyethylene Glycol (Miralax)3350 Kit give 17 mg by mouth one time a day for laxative. Ascorbic Acid tablet give 500 mg (milligrams) by mouth one time a day for supplement. Docusate Sodium tablet give 100 mg by mouth every 12 hours for laxative. Escitalopram Oxalate tablet give 10 mg by mouth one time a day for antidepressants. Lisinopril tablet 5mg give 1 tablet by mouth one time a day for hypertension ... Nephro-vite tablet 0.8mg give by mouth one time a day for multivitamin. Sennoside Tablet give 8.6 mg one time a for laxative. During a face-to-face interview on 08/23/2021 at approximately 9:40 AM, Employee #36 was asked, if she was going the administer the Miralax after touching the straw with her gloved hand that touched the "dirty clothes hamper?" She stated that she was going to administer because she did not realize she had touched the resident ' s straw. The employee then stated that she would discard the Miralax and start over. Employee #36 was then asked if it was the facility ' s policy to administer medications from the top	L 091		

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of the "dirty clothes hamper", the employee stated, "I cleaned it when I came in this morning at 8:00 AM." When asked, how could she ensure the "dirty clothes hamper" was still clean at 9:40 AM, Employee #36 failed to provide an answer.

4. Review of the facility ' s policy entitled, "COVID-19 Guidelines for Quarantine and Testing of Patients & Healthcare Providers" revised on 10/09/2020, documented, "PPE (personal protective equipment) requirements ... eye shield (goggles or face shield) at all times when working with the patients/residents ..."

Facility signage for Enhanced Barrier Precautions stipulated the following:
"Enhanced Barrier Precautions
Everyone Must:
Clean their hands, including before entering and when leaving the room.

Providers and Staff must also:
Wear gloves and a gown for the following:
High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting
Device care or use:
Central line, urinary catheter, feeding tube, tracheostomy
Wound Care: any skin opening requiring a dressing
Do not wear the same gown and gloves for the care of more than one person"

4A. During an observation on Unit 3 West on 08/23/2021 at 5:40 AM, Employee #33 (Certified Nurse ' s Aide) was observed doing direct patient

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care on a resident without an eye field. It should be noted that the resident had a sign at his door that directed, "Droplet Precautions ...everyone must ... wear eye protection if splash/spray to eyes likely ..."

During a face-to-face interview conducted on 08/23/2021 at 11: 00 AM, Employee #1 (Administrator) stated, "All staff are required to wear a face shield when they are doing any direct patient care."

4B. During an observation on Unit 3 West on 08/24/2021 at 11:52 AM, it was noted that the soap dispenser in room 337 was not functioning. Right below the non-functioning soap dispenser was a bottle of "soothe & cool cleanse shampoo and body wash". It should be noted that room 337 had a sign on the door that directed, "Enhanced Barrier Precautions ... Everyone must clean their hands, including before entering and when leaving the room ..."

During a face-to-face interview conducted at the time of the observation, Employee #34 (Environmental Services) stated, "I was not made aware that the soap dispenser was out. I checked it and it only needs new batteries."

4C. During an observation on Unit 2 East on 08/24/2021 at 1:11 PM, a pile of soiled linen was noted sitting on top of the sink in resident room 207.

During a face-to-face interview conducted at the time of the observation, Employee #23 (Unit Manager) acknowledged the findings and stated, "I know, I should've brought a dirty linen bin to place the dirty linens in."

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L 091	Continued From page 117	L 091		

4D. During an observation on Unit 3 West on 08/31/2021 at 11:58 AM, Employee #35 (Registered Nurse) was observed leaning on the bed of the resident in room 333 Bed A while assisting the resident to drink. The employee was not wearing a gown or gloves. It should be noted that room 333 had a sign on the door that directed, "Enhanced Barrier Precautions ... providers and staff must wear gown and gloves ..."

During a face-to-face interview conducted at the time of the observation, Employee #35 stated that he should've been wearing a gown.

5.Facilty staff failed to sanitize her hands prior to entering a resident's room to provide care.

On 8/23/2021 at approximately 5:50 AM, Employee # 47 was observed caring for Resident #100 in room #159-A. The signage outside the door to room 159 stated, "Enhanced Barrier Precautions" Everyone must: Clean their hands including before entering and when leaving the room."

Employee # 47 was observed leaving her medication cart and entered room #159 without first sanitizing/cleaning her hands. She then hung an enteral feeding bottle for Resident #100. Employee #47 then changed her gloves while in the room and proceeded to suction Resident #100's tracheostomy. Employee #47 then removed her gloves and sanitized her hands when she exited the room.

At the time of the observation, Employee #47

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L 091	Continued From page 118 acknowledged being aware of the hand hygiene policy and offered no comment about why she did not perform hand hygiene before entering the residents room. There was no eveidence that facilty staff sanitized her hands prior to entering a resident's room to provide care.	L 091		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on observations and staff interview, the facility failed to serve foods under sanitary conditions as evidenced hot foods temperatures that were below 140 degrees Fahrenheit on three (3) of nine (9) observations and a cooling fan that was in use, in the kitchen. The findings include: 1. During a food test tray assessment on August 30, 2021, at approximately 1:15 PM, and on September 1, 2021, at approximately 1:30 PM, hot foods such as noodles (110 F), spinach (120 F), and puree fish (114 F) tested below 135 degrees Fahrenheit (F). 2. A cooling fan was being used in the kitchen during a walkthrough of dietary services on August 23, 2021, at approximately 6:00 AM.	L 099	**L 099** **Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, andserved in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40.** 1. Corrective action for resident Cooling fan has been removed and food temperatures have been consistently within required range. 2. Identify other residents All residents could have been affected. There were no additional findings related to this citation. 3. Systemic changes Dietary and Engineering staff have been educated on the importance of ensuring that cooling fans are not used in the kitchen. The Dietary staff was also educated on food safety to include proper food temperatures. The Director of Dietary will be responsible for ensuring that food safety requirements are met. 4. Monitor corrective actions The Director of Dietary/Designee will complete daily audits of food temperatures to ensure that food temperatures are within acceptable range. In addition, the Director of Dietary/Designee will complete random test tray audits weekly. The Director of Facility Management will do weekly audits of the kitchen to ensure that no cooling fans are in use. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	11/02/2021

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L 099	Continued From page 119 These observations were acknowledged by Employee #46 on September 1, 2021, at approximately 3:00 PM.	L 099	**L 128** **The supervising pharmacist** 1. Corrective action for resident	11/02/2021
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a) Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d) Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e) Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on observation, record review and staff interview, facility staff failed to accurately reconcile narcotics. The findings include:	L 128	The nurse signed out the medication that had been previously given and all counts were reconciled and correct. Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration. 2. Identify other residents All other narcotic books were reviewed. No residents were affected. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of accurate accounting of narcotic medications and documentation of medication administration. The Director of Nursing will be responsible for ensuring that nurses accurately count and document narcotic medications. 4. Monitor corrective actions The Director of Nursing/Designee will complete random weekly audits of 10 % of narcotic count sheets to ensure that medication counts match the medication on hand correctly and are documented when given. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance.	

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L 128	Continued From page 120 During a review of the narcotic storage box on 08/23/2021 at 6:51 AM on Unit 3 West, it was observed that a resident's medication blister packet labeled, "Diazepam (antianxiety) 2 mg (milligram) tab (tablet) 1 tab by mouth at bedtime", had 20 remaining tablets. However, the narcotic book documented, "21" tablets should be remaining. During a face-to-face interview conducted at the time of the observation, Employee #31 (Registered Nurse) stated, "I gave the resident one tablet last night at 10:00 PM but I forgot to sign it off in the book."	L 128	5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	
L 161	3227.12 Nursing Facilities Each expired medication shall be removed from usage. This Statute is not met as evidenced by: Based on observation and staff interview, facility staff failed to safely store medications. The findings include: During an observation of 3 west, Team 2 medication cart on 08/25/2021 at 10:50 AM, three (3) resident's Glucagon (treatment for low blood sugar) pens documented an expiration date of "01/2021". During a face-to-face interview conducted at the time of the observation, Employee #21 (Registered Nurse) stated that she would remove the expired Glucagon pens from the medication cart.	L 161	**L 161** **Each expired medication shall be removed fromusage.** 1. Corrective action for resident Medication carts and rooms are free of expired medications. 2. Identify other residents An audit of all medication carts and medication rooms was completed. There were no additional findings related to this citation. 3. Systemic changes Nursing staff have been educated on the importance of ensuring that no expired medications are left on medication carts or in medication rooms. The Director of Nursing will be responsible for ensuring that no expired medications are left in medication carts or	11/02/2021
L 199	3231.10 Nursing Facilities	L 199		

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L 199	Continued From page 121 Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of the care given to the resident. This Statute is not met as evidenced by: Based on record review and staff interview, for three (3) of 44 sampled residents, facility's staff failed to: accurately document the resident's weight for one (1) resident; accurately document the side effects as ordered by the physician and as directed in the care plan for a resident receiving psychotropic medications for one (1) resident; and record the administration of the resident receiving Symbicort Aerosol and Peri trach care on the Treatment Administration Record and Respiratory Medication Administration for one (1) resident. Residents' #3, #5 and #119. The findings include: 1.Resident #3 was admitted to the facility on 07/10/2021 with multiple diagnoses including Morbid Obesity, Cellulitis, and Lymphedema ... Review of the medical record showed a hospital discharge summary from a local hospital that documented Resident #3 ' s weight as 179.7 kilogram (396 pounds) on 07/02/2021. Review of Resident #3 ' s Weight Summary List revealed that the resident weighed 285 pounds on 07/10/2021 and 497.5 pounds on 08/04/2021, which was difference of 212.5 pounds (72.15% weight gain) in 25 days. During a face-to-face interview with 08/30/2021 at approximately 10:00 AM, Employee #28 (Registered Dietician) stated that she recognized	L 199	medication rooms. 4. Monitor corrective actions The Unit Managers and Supervisors/Designee will complete random weekly audits of 1 unit to ensure that no expired medications are present. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021. **L 199** **Each medical record shall document the course of the resident's condition and treatment and serve as a basis for review, and evaluation of thecare given to the resident.** 1. Corrective action for resident Resident #3 has been re-weighed and their current weight has been documented and verified by the Dietician. Resident #5 has been evaluated by a psychiatrist and assessed for the effectiveness of their psychotherapeutic medications. Resident #119 has received the ordered respiratory medications and treatments and they are being signed off as appropriate on the Treatment Administration Record and Respiratory Medication Administration Record.	11/02/2021

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L 199	Continued From page 122 the weight discrepancy and instructed staff to re-weight the resident. Employee # 28 was asked which weight was the accurate weight? She stated, "The 497.5 pounds was the resident ' s accurate rate." 2. Resident #5 was admitted to the facility on 02/22/2017 with multiple diagnoses that included: Anxiety Disorder, Depression and Tracheostomy Status. Review of the physician ' s orders revealed: 01/02/2020 "Is resident free from side effects of psychotherapeutic medications if no, document side effects in PN [progress note] very shift" 07/10/2021 "Quetiapine Fumarate (antipsychotic) tablet 25 MG (milligram) give 0.5 tablet via PEG (percutaneous endoscopic gastrostomy)- Tube at bedtime for agitation hold for sedation" Review of the Annual Minimum Data Set (MDS) dated 08/08/2021 revealed that facility staff coded the following: In Section C (Cognitive Patterns), cognitive skills, "severely [cognitively] impaired" In Section D (Mood), staff assessment of resident mood, " total severity score 00" (indicating the resident shows no sign of depression) In Section E (Behavior), psychosis, behavioral symptoms, "none ... behavior not exhibited" In Section I (Active Diagnosis), "Non Alzheimer's Dementia, Restlessness and Agitation"	L 199	2. Identify other residents An audit of other residents was completed. There were no additional findings related to this citation. 3. Systemic changes Nursing staff and Dietician have been educated on the importance of ensuring that residents are weighed accurately and weights documented. Nursing and Social Services staff have been educated on the importance of ensuring that residents are evaluated by a psychiatrist and their psychotherapeutic medications are assessed for effectiveness per physician orders. Respiratory Therapists were educated on the importance of documenting respiratory medications and treatments are documented on the Treatment Administration Record and Respiratory Medication Administration record. The Director of Nursing, Dietician, Director of Cardiopulmonary Services, and Director of Social Services will be responsible for ensuring that medical records are complete for their respective disciplines. 4. Monitor corrective actions The Unit Managers and Nursing Supervisors/Designee will complete weekly audits of 10% of residents to ensure that medical records are complete and accurate. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed	

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L 199	Continued From page 123 In Section N (Medications), medications received, "antipsychotic" Review of the care plan revealed: Focus area: "12/26/2019 [Resident #5] is receiving psychoactive medication Seroquel (Quetiapine Fumarate) daily for depression ..., interventions: " ... assess/monitor/document behavior daily on behavior monitoring sheet ..." Focus area "04/25/2018 [Resident #5] is on 9+ medicines ..., interventions: " ...Monitor for possible signs and symptoms of adverse drug reaction: falls, weight loss, fatigue, incontinence, agitation, lethargy, confusion, agitation, depression, poor appetite, constipation, gastric upset ..." Review of the Treatment Administration Record (TAR) revealed a section labeled, "Is resident free from side effects of psychotherapeutic medications (if no, document side effects in PN) every shift". In this section, it was noted that from dates 08/01/2021 to 08/25/2021, facility staff documented nine (9) times, "N (no)", indicating Resident #5 was not free of psychotherapeutic side effects. Review of the progress notes from 08/01/2021 to 08/25/2021 lacked documented evidence that the facility staff documented Resident #5's chotherapeutic side effects. During a face-to-face interview conducted on 08/26/2021 at 11:11 AM, Employee #2 (Director	L 199	The facility's date of alleged compliance is November 2, 2021.	

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L 199	Continued From page 124 of Nursing) had no comments about the findings. 3. Resident #119 was admitted to the facility on 08/03/2021 with diagnosis that included Chronic Obstructive Pulmonary Disease (Acute) Exacerbation, Chronic Respiratory Failure with Hypoxia, and Encounter for Attention to Tracheostomy. According to the Admission MDS completed on 08/10/2021,the resident was coded as having a Brief Interview for Mental Status (BIMS) of "15" indicating she had no cognitive impairment and under Section O (Special Treatments and Programs) she was coded as "While a Resident" she received oxygen therapy, suctioning and tach care. Review of the Treatment Administration Record and Respiratory Medication Administration Record for August 2021 showed the following: "Symbicort Aerosol 160-4.5 Mcg/ACT 2 (helps to control asthma and used for maintenance treatment of chronic obstructive pulmonary disease) puff inhale orally two times a day was not signed as being administered on 8/12/2021, 8/14/2021, 8/16/2021, 8/18/2021 at 2200 (10:00 PM); and 8/19/2021 and 08/22/2021 at 1000 AM. "Clean Peri trach with normal saline, pat dry apply gauze every (unable to read) care and as needed was not signed as being completed on day 08/06/2021, 08/16/2021, and 08/22/2021; and on "night" 08/05/2021, 08/12/2021, and 08/18/2021."	L 199		

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L 199	Continued From page 125 Review of the Respiratory Treatment Care Assessment for the aforementioned dates showed that a respiratory therapist administered the Symbicort Aerosol and performed Peri trach care as ordered by the physician. Although the medication and treatment were administered by the Respiratory Therapist, the staff failed to record the administration of the resident receiving Symbicort Aerosol and Peri trach care on the Treatment Administration Record and the Respiratory Medication Administration record. During a face-to-face interview on 09/01/2021 at 8:36 AM, Employee #2 (Director of Nursing Services) made no comments to address the findings.	L 199		
L 204	3232.2 Nursing Facilities A summary and analysis of each incident shall be completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and shall include the following: (a)The date, time, and description of the incident; (b)The name of the witnesses; (c) The statement of the victim; (d) A statement indicating whether there is a pattern of occurrence; and (e) A description of the corrective action taken.	L 204	**L 204** **A summary and analysis of each incident shall becompleted immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing** 1. Corrective action for resident Investigations were reviewed and reinvestigated and appropriate actions taken to resolve the concerns for all residents. Employees #5 and #49 were terminated. Resident #95 is restrained for their safety appropriately. Resident #37 has her IPAD at her bedside. Resident #102’s concerns were reviewed and addressed during the IJ abatement process. Residents #23and Resident # 105 no longer reside in the facility.	11/02/2021

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L 204	Continued From page 126 This Statute is not met as evidenced by: Based on record review and staff interview, for five (5) of 11 complaints and facility reported incidences, facility staff failed to ensure a summary and analysis of each incident was completed immediately and reviewed within forty-eight (48) hours of the incident by the Medical Director or the Director of Nursing and thoroughly conduct an investigation: for three (3) residents who alleged physical abuse from an employee; for an allegation of misappropriation of one (1) resident's property; and for improper use of a restraint for one (1) resident. (Residents' #23, #37, #95, #102 and #105). The findings include: Review of the facility's policy entitled, "Abuse Investigation and Reporting" with a review date of 08/2020 revealed, " ...The individual conducting the investigation will, as minimum... interview the resident (as medically appropriate) .. interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident ... interview other residents to whom the accused employee provides care or services ..." 1. Facility staff failed to thoroughly investigate an incident for Resident #23 who alleged physical abuse. Resident #23 was admitted to the facility on 11/14/2020, with diagnoses that included: Anemia, Heart Failure, Hypertension, Renal Insufficiency, Diabetes Mellitus, Anxiety Disorder and Asthma. According to the Quarterly MDS dated	L 204	2. Identify other residents An audit of all other resident's completed. There were no additional findings related to this citation. All FRIs from January 2021 to present were reviewed and reinvestigated and appropriate actions taken to resolve the concerns for all residents. Education files of any staff involved in the FRIs were reviewed to ensure that appropriate actions were taken regarding their involvement. 3. Systemic changes Staff and Leadership have been educated on the importance of ensuring that all allegations of abuse are reported and investigated appropriately to ensure that residents are not subjected to potential abuse. The Administrator will be responsible for ensuring that residents are not subjected to potential abusive situations secondary to the failure to properly investigate allegations of abuse. 4. Monitor corrective actions The Administrator will complete weekly audits of all Incidents Reported by the Facility to ensure that all investigations are investigated thoroughly. The results will be reported to the QAPI Committee monthly x 2 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is September 15, 2021.	

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02/21/2021, Resident #23 was coded as "rarely/never understood" and was not able to conduct the Brief Interview for Mental Status.

Review of the incident report dated 04/22/2021 revealed: " ...the daughter called to say that her mother accused staff member [Employee #49] (Certified Nurse's Aide) of hitting her. She was not able to give a date or time or when the incident occurred." " ...the resident is not a reliable witness and the daughter could also not give the place of the alleged strike. The employee was suspended, and an investigation was initiated ...the resident was assessed for bruises and pain and found to not be in distress."

During an interview with Employee #1 (Administrator) on 09/08/2021 at approximately 9:40 AM, he stated the investigation was unsubstantiated and the employee was allowed to return to work.

During the time of the survey, a review the facility's investigation was conducted and revealed that four (4) residents were interviewed, and three (3) staff were interviewed.

The interview questions posed to the residents related to the care that the CNA provided.

One resident stated, "Her care is poor. She don't do what I want her to do. A couple of time she had me I thought I was going to die."

One resident stated, "She is okay, but sometimes she gives me a hard time with my colostomy."

One resident stated, "Her care with me is average. She sometimes forgets to feed me. I get mad a her."

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One resident stated, "She does not come to my room to care for me. I have been complaining about her, nobody does anything. When she has me, she don't do nothing for me. She is always hiding."

The staff/co-workers of the CNA provided the following responses to the interview questions:

"She is good but grudgingly do stuff."

"Her care is not good. She does not care for the residents. We have to wash the residents."

"I think her care is pretty good. I have heard the residents complain about her."

There was no evidence that the facility staff who conducted the interviews further investigated the other four (4) residents and three (3) other staff complaints/reported concerns related to the involved CNA.

During a face-to-face interview conducted on 09/08/2021, at approximately 9:40 AM with Employee #1, he had no comments about the findings.

2. Facility staff failed to thoroughly investigate the family's complaint that Resident #37's IPAD (electronic device) was missing.

Resident #37 was re-admitted to the facility on 09/01/2020 with the following diagnoses: Anemia, Hypertension, Diabetes Mellitus, Hyperlipidemia and Cerebral Vascular Accident (CVA).

A review Resident #37's Admission Minimum Data Set (MDS) dated 08/12/2021 revealed:

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In Section C (Cognitive Patterns), Resident #37 had a Brief Interview for Mental Status (BIMS) Summary Score of "15" indicating intact cognition.

In Section G (Functional Status), Resident #37 was coded as, "total dependence, one-person physical assist," for dressing, toilet use, and personal hygiene.

A review of a Facility Reported Incident (FRI) dated 8/19/2021 at 4:52 PM documented the following:

" ... The resident's daughter complained that her mother's IPAD (electronic device) was missing, and then when it was found under her mother the DON (Director of Nursing) failed to give a report as to how the IPAD fell off the device it was connected to...after she complained the aide [Employee #25] yelled at her mother [Resident #37], [and] closed the door isolating her mother. [Employee #25] was the identified aide, the facility suspended the associate [Employee #25] and initiated an investigation."

On 08/20/2021 a memo to the State Agency from Employee #1 (Administrator) documented, " ...We interviewed the staff, roommate, and other residents on the unit along with examining the medical chart. The resident was currently under quarantine, so the door was closed per protocol. The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident in question, Therefore, the case has been unsubstantiated due to these findings."

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A review of the facility's investigative notes and documents on 08/30/2021 lacked documented evidence of interview statements from Resident #37, Resident #37's daughter and Employee #25.

During a face-to-face interview conducted on 08/31/2021 at 3:57 PM, Employee #1, stated that all interview questions and statements should have been included in the folder with the other documents for the investigation. He reported that the initial complaint made by Resident #37's representative (daughter) was considered the interview statement of what happened. He also stated that he would check with Employee #2 (Director of Nursing) in regards to the interview questions from Employee #25 (CNA involved). The Administrator did not provide the missing interview questions and statements from Resident #37 prior to the survey exit.

3. Facility staff failed to thoroughly investigate the incident of Resident #95's hand mitten being tied to the bedrail.

Resident #95 was admitted to the facility on 01/19/2021, with multiple diagnoses that included: Cerebral Infarc due to Embolism of Left Middle Cerebral Artery, Restlessness and Agitation, Attention for Encounter Gastrostomy and Attention for Encounter Tracheostomy.

Review of the physician's orders revealed the following:

01/19/2021 "Assess left wrist restraint q (every) 2 hours and document any findings every 2 hours"

01/19/2021 "Keep left wrist restraint in place to prevent patient from pulling on her trach (tracheostomy) or G (gastrostomy) - Tube q shift"

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L 204	Continued From page 131 Review of Resident #95's Admission (MDS) dated 01/26/2021, revealed that facility staff coded the following: In Section C (Cognitive Patterns), "Severely impaired" In Section E (Behavioral Symptoms), " ... Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) ... Behavior of this type occurred 1 to 3 days" In Section G (Functional Status), "Bed mobility ... total dependence, one-person physical assist" In Section P (Restraint), "Limb restraint [hand mitten] ...Used daily" Review of a Facility Reported Incident (FRI) on 01/27/2021 documented, " ... During rounds on 1/27/2021 her (Resident #95) mitten was found tied to the rail. It was immediately released, and the patient was assessed ...Investigation is ongoing ..." Review of the progress notes revealed: 01/27/2021 1:18 PM (Administrator note) "[Resident name] ...During rounds on 1-27-2021 her mitten was found tied to the rail. It was immediately released and patient was assessed and not found to be in distress, pain or fearful. Resident's physician, RP (representative) and appropriate agencies were notified. House wide sweep conducted no other residents were found to have an inappropriate restraint. Investigation is ongoing. Son was satisfied and we told him we	L 204		

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will be in communication with the conclusion."

Review of the facility's investigation notes and documents on 08/31/2021 revealed that only six (6) staff members were interviewed as part of the investigation. There was no documented evidence of interviews from the respiratory therapist who provided Resident #95 with tracheostomy care or from the environmental staff who cleaned Resident #95's room.

It was also noted that two staff members answered "no" when asked, "Do you know the abuse reporting policy and procedure" as part of the investigation ' s interview questions.

There was no documented evidence that the investigator(s) followed up with those staff members nor is there documented evidence that any additional training/education was provided on restraints or the facility ' s abuse reporting policy and procedure.

Employee #1 (Administrator) acknowledged that Resident #95 was physically tied to the bedrail however, he did not substantiate that abuse occurred.

During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #2 (Director of Nursing) stated, "Mittens are used for residents who are a danger to themselves. After the incident, we interviewed the staff, assessed the resident and did audits of the other residents in the facility with hand mittens. We did not find any other residents with mittens tied to the bedrail."

During a face-to-face interview conducted on 08/31/2021 at 9:45 AM, Employee #1 (Administrator) stated, "We couldn't substantiate

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the allegation. Based on the staff interviews, we could not determine who tied the resident to the bed rail. It could have been a staff, contractor or family member. We audited the facility and did not find any other resident with hand mittens tied to the bed."

During a face-to-face interview conducted on 08/31/2021 at 10:54 AM, Employee #4 (Speech and Language Pathologist) stated, "The resident is nonverbal with right hemiparesis- pretty close to paralyses. Left side is intact. She had an order for left [hand] mitten. I walked into the room (on 01/27/2021) and noticed the straps to the mitten were wrapped around and tied to the upper bed rail, fully restricting her movement of the left hand. I immediately removed the restraint, made the nurse aware and educated the nurse that the mitten was not to be used as a restraint. I then reported the incident to my supervisor and the administrator."

It should be noted that a review of facility's visitation log on 08/31/2021 at 10:00 AM revealed that Resident #95 did not have any visitors on 01/26/2021 or 01/27/2021.

4. Facility staff failed to thoroughly investigate Resident #102's complaint that a staff member snatched his leg and slung it during care.

Resident #102 was re-admitted to the facility on 06/25/2021, with multiple diagnoses that included: Multiple Fractures of Ribs, Acute Chronic Respiratory Failure with Hypoxia, and Pressure Ulcer of Sacral Region.

The Employee #50's (Certified Nurse's Aide) statement dated 07/10/2021, documented, "Unfortunately I went to [Resident #102] said to

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L 204	Continued From page 134 him we are here to clean ... My nurse was [Employee name] we turned over the patient ..." Review of a complaint and facility reported incident dated 07/14/2021 revealed the following: " ... [Resident #102] stated when staff was providing him with care snatched his leg and slung it requesting he [turn] over resident stated that he is in pain. Resident alleges that staff person told him big boy you can take a little pain. Resident was able to identify staff persons who were providing him care. An investigation is being conducted staff has been suspended pending ongoing investigation." Review of a memo from Employee #1 (Administrator) dated 07/14/2021, revealed, " ... The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident in question. Therefore, the case has been unsubstantiated due to these findings." Review of the facility's investigation notes and documents on 08/26/2021, revealed that the investigation failed to obtain a statement from the Registered Nurse (RN) who was mentioned as being present in Resident #102's room during the alleged incident. There were seven (7) pre-printed interview questionnaire forms and one handwritten statement written by the involved Employee #50. The pre-printed interview questions were answered by staff and other residents. Three (3) out of the seven (7) investigation questionnaire forms had questions that were left blank. All the pre-printed investigation questionnaire forms had names that were illegible.	L 204		

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During a face-to-face interview conducted on 08/26/2021, at approximately 9:50 AM, Employee #1(Administrator) stated, "I came in, did investigations and interviewed staff."

5. Facility staff failed to thoroughly investigate Resident #105's complaint that Employee #5 stuffed her brief with pieces from a incontinence pad and made a negative verbal comment.

Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome.

Review of Resident #105's Significant Change Minimum Data Set (MDS) dated 07/13/2021, revealed that facility staff coded the following:

"In Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) score "15", indicating intact cognitive response.

"In Section E (Behavior), Hallucinations (perceptual experiences in the absence of real external sensory stimuli) "No"; Delusions (misconceptions or beliefs that are firmly held, contrary to reality) "No";

"and in Section GG (Functional Abilities and Goals), Toileting hygiene "... total dependence ... one-person physical assist".

Review of Employee #5's personnel file on 09/08/2021 revealed a form entitled; "[Facility's Name] Employee Warning Notice" dated 07/29/2020. The form revealed that Employee #5 received a verbal warning on (07/16/2020) and a written warning on (07/20/2020) for "violation of

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policy/procedure".

Attached to the previously mentioned warning notice was a document written by the (previous) Director of Nursing that revealed the following:

"On the morning of July 16, 2020, it was brought to the attention of the Director of Nursing by Wound Care Team member... a resident [that resided on unit 3 east] was observed with a urine filled incontinence brief on and a urine saturated Ultrasorb (under pads) in the incontinence Brief. CNA (Employee #5) ... was asked about the use of the under pads inside of the resident ' s diaper. [Employee #5] said [Resident's Name] is a heavy wetter..."

"On the morning of July 20 [2020] ... Resident 330 A [unit 3 west] had a urine stained Ultrasorb under pad taped together to form a incontinence brief and was taped to the resident's skin...Resident 330 B [the previously mentioned resident's roommate] was observed with the same makeshift incontinence brief and in addition urine soaked towel was found between the resident's legs... This is the second occurrence within one week where [Employee #5] provided care to residents in a manner ... [Employee #5] should not provide... The type of care provided by [Employee's Name] to the residents is a Type B Offense... Acting in a way that can be considered abuse or neglect, or mistreatment of a patient/resident either physically, mentally or verbally."

On 08/19/2021 a complaint was received by the State Agency that documented, "[Resident #105] ...reported to the Ombudsman... on the night of August 18th the nursing Aide stuffed [Resident #105's] brief with pieces from a chuck

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(incontinence pad) and said 'I am not changing you again tonight' ..."

Review of a memo from Employee #1 (Administrator) dated 08/24/2021, documented, " ... We interviewed the staff and other residents on the unit (3 west) along with examining the medical chart. The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident [Resident #105] in question. Therefore, the case has been unsubstantiated due to these findings."

On 08/27/2021, a complaint was received by the State Agency that documented, "[Resident name]... The residents daughter reported to the Ombudsman ... C.N.A. (Certified Nurse's Aide) ... told the resident 'she caused him three days of pay, and that she talks too much."

During a face-to-face interview conducted on 08/30/2021 at 9:06 AM, Employee #1 (Administrator) stated, "The staff member [Employee #5] and the Nurse Supervisor knew not to assign him to work with the resident (Resident #105). There was obviously a breakdown in the system. The involved CNA was floated to 3 west (where Resident #105 resided). He was not originally assigned to that unit. He [Employee #5] reported that he did not say anything to [Resident #105] while he was providing care. The supervisor is getting reprimanded, and the involved CNA was suspended (on 08/27/2021) and is being terminated as of today."

During a face-to-face interview conducted on 08/30/2021 at 9:17 AM with Employee #2

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(Director of Nursing), she stated, "We don't tolerate abuse. I do hand-off (transfer of patient care and responsibility from one healthcare provider to another) communication with the supervisors during the week. The supervisors were made aware that the CNA involved was not to work on the third floor at all."

During a telephone interview conducted on 08/30/2021 at 10:36 AM, Employee #6 (Nurse Supervisor) stated, "The CNA [Employee #5] was floated to 3 West because we didn't have a CNA for that unit. I was told that the CNA shouldn't be floated to 3 East. I was not made aware about the issues on 3 West."

During a telephone interview conducted on 08/30/2021 at 10:50 AM, Employee #5 stated, "I was working on 2 East and was pulled to 3 West because they were short. I was told the investigation was resolved and no issues were found, so I went to the unit (3 west). I was taking care of the roommate (room 333 bed B) when [Resident #105] stated that she was wet and needed assistance as well. I reminded her that she made a report on me and that I didn't want any problems. The resident stated that she wanted me to help her and so I did. There were no issues during the ADL (activities of daily living) care. I have been doing this for 17 years. I have never done anything to her nor intimidate her in any way."

Review of the investigation notes and documents for Resident #105's complaint revealed there was no documented evidence that the facility's staff reviewed Employee #5's personnel record or implemented measures to protect all residents including Resident #105, from the potential of "abuse or neglect, or mistreatment of a

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L 204	Continued From page 139 patient/resident either physically, mentally or verbally." Additionally, Employee #5's personnel record failed to outline why the employee was not allowed to work on unit 3 East. During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #7 (Director of Human Resources) stated, "The previous disciplinary actions (that occurred in 07/2020) were not mentioned to the Director of Nursing until a meeting that occurred on 08/31/2021 when termination (of Employee #5) was discussed." During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated, "I was not aware of any previous allegations made for Employee #5 (CNA) until the meeting on 08/31/2021." During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #1 (Administrator) stated, "I was not aware of any previous allegations or disciplinary actions for the employee (Employee #5). I did not review his personnel file as part my investigation."	L 204		
L 214	3234.1 Nursing Facilities Each facility shall be designed, constructed, located, equipped, and maintained to provide a functional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public. This Statute is not met as evidenced by: Based on observations and interview, the facility failed to provide an environment free from accident hazards as evidenced by a portable space heater that was seen in one (1) of 76 resident's rooms.	L 214	**L 214** **Each facility shall be designed, constructed, located, equipped, and maintained to provide afunctional, healthful, safe, comfortable, and supportive environment for each resident, employee and the visiting public.** 1. Corrective action for resident Resident #93 was educated on signing out when leaving the facility. The heater was removed from room 335. The resident was educated that such devices are a safety hazard and not permitted.	11/02/2021

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L 214	Continued From page 140 The findings include: During a walkthrough of the facility on August 30, 2021, at approximately 12:00 PM, a portable space heater was stored on the floor in resident room #335 on the 3 West unit. The space heater was plugged in an electrical outlet, ready for use. Employee #1 acknowledged the findings during a face-to-face interview on September 1, 2021, at approximately 4:00 PM.	L 214	2. Identify other residents An audit of other resident LOAs was completed. An audit of resident rooms did not yield any additional heaters. There were no additional findings related to this citation. 3. Systemic changes Nursing and security staff have been educated on the importance of ensuring that residents are signed out appropriately and accounted for and no heaters are present. Nursing staff have been educated on the importance of accurate documentation and validation of resident whereabouts throughout the shift. The Director of Security will be responsible for ensuring that residents are engaged upon exit of the facility to ensure that they have notified nursing staff of their whereabouts. 4. Monitor corrective actions The Director of Nursing/Designee will complete weekly audits of all residents who go out on LOAs to ensure that their absence and related documentation is accurate. The Engineering department will audit 25% of resident's rooms monthly for unauthorized appliances. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	
L 247	3238.3 Nursing Facilities Each room that is used by a resident shall be maintained at a minimum temperature of seventy-one degrees Fahrenheit (71°F) and a maximum of eighty-one degrees Fahrenheit (81°F) at all times when the room is occupied. This Statute is not met as evidenced by: Based on observation and staff interview, facility staff failed to provide a comfortable and homelike environment as evidenced by the facility failing to ensure that occupied resident room temperatures were maintained between seventy-one degrees Fahrenheit (71°F) and a maximum of eighty-one degrees Fahrenheit (81°F). The findings include: During a walkthrough of unit 3 west on 08/23/2021 at approximately 8:30 AM resident room temperatures with Employee #37 (Director of Plant Operations), using the facility's infrared thermometer, temperature levels registered above 81 degrees Fahrenheit in five (5) out of	L 247		

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BRIDGEPOINT SUBACUTE AND REHAB NATIONAL H	4601 MARTIN LUTHER KING JR AVENUE SW WASHINGTON, DC 20032

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L 247	Continued From page 141 (five) resident rooms: room 337, 81.9 degrees Fahrenheit; room 336, 85.5 degrees Fahrenheit; room 339, 86.7 degrees Fahrenheit; room 335, 89.4 degrees Fahrenheit and room 334, 81.7 degrees Fahrenheit. At the time of the observation, Employee #37 acknowledged the findings.	L 247	**L 247** **Each room that is used by a resident shall bemaintained at a minimum temperature of seventy-one degrees Fahrenheit (71°F) and amaximum of eighty-one degrees Fahrenheit (81°F) at all times when the room is occupied.** 1. Corrective action for resident No areas are greater than 81°F. Resident #68's low-air pressure mattress has been replaced. The air handler is being addressed. Residents were checked with no concerns raised about individual room temperatures. 2. Identify other residents An audit of resident rooms and common areas did not reveal any areas at or greater than 81°F. An audit of resident beds was completed. There were no additional findings related to this citation. 3. Systemic changes Staff have been educated on the importance of ensuring that mechanical, electrical, and patient care equipment are in safe working condition (to include initiating service requests for equipment in need of repair/servicing). The Director of Engineering, Materials, and Biomedical Engineering Technician will be responsible for ensuring that mechanical, electrical, and patient care equipment are in safe working condition. 4. Monitor corrective actions Engineering/Designee will complete weekly audits of mechanical, electrical, and patient care	11/02/2021
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations and interview, facility staff failed to provide housekeeping services necessary to maintain a safe, clean, comfortable environment as evidenced by five (5) ceiling tiles in the supply room that were stained throughout and two (2) ceiling tiles in the staff breakroom that were also soiled. The findings include: During an environmental walkthrough of the facility storage room in material management on September 1, 2021, at approximately 1:00 PM, five (5) ceiling tiles in the main supply room and two (2) ceiling tiles in the staff break room were marred with dark stains throughout. Employee #37 acknowledged the findings during a face-to-face interview on September 1, 2021, at approximately 4:00 PM.	L 410		

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L 521	Continued From page 142	L 521	equipment service requests to ensure that they are in safe working condition. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	
L 521	3269.1d Nursing Facilities (d) To be treated with respect and dignity and assured privacy during treatment and when receiving personal care; This Statute is not met as evidenced by: Based on observations, record review and staff interviews for one (1) of 44, sampled residents the facility ' s staff failed to ensure a resident was provided dignity and privacy due to not covering the urine collection bag. (Resident #102). The findings include: Resident #102 was re-admitted to the facility on 06/25/2021 with multiple diagnoses including Stage 4 Pressure Ulcer of sacral area, Stage 4 bilateral buttocks pressure ulcers, Multiple Fractures of Ribs, and Unspecified Fracture of lower end of right Femur. On 08/24/2021 at approximately 4:00 PM, Resident #102 was observed in his room with his urine collection bag uncovered and filled to capacity with urine. Review of a physician order dated 06/26/2021, directed - "Foley (catheter) size # 18 ...Measure urine output every shift ..." Review of the Quarterly Minimum Data Set (MDS) dated 08/17/2021 revealed in Section H (Bladder and Bowel) the resident was coded as "A" indicating the presence of an indwelling catheter. During a face-to-face interview on 08/24/2021 at approximately 4:00 PM, Employee # 36 (Registered Nurse) stated "A family member was	L 521	**L 410** **Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner.** 1. Corrective action for resident The ceiling tiles in the main supply room and the staff break room have been replaced. 2. Identify other residents An audit of other areas throughout the facility were inspected. There were no additional findings related to this citation. 3. Systemic changes Engineering staff have been educated on the importance of maintaining a safe, clean, and comfortable environment. The Director of Plant Operations will be responsible for maintaining a safe, clean, and comfortable	11/02/2021

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L 521	Continued From page 143 going and she touch it (urine collection bag) by accident". The employee made no further comments to address why Resident #102's urine collection bag was not covered.	L 521	environment. 4. Monitor corrective actions The Director of Plant Operations/Designee will complete random audits of ceiling tiles on one unit weekly and will follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021.	
L 526	3269.1i Nursing Facilities (i) To keep and use personal clothing and possessions, as space permits, unless to do so would infringe on other residents' rights or is medically contraindicated; This Statute is not met as evidenced by: Based on a review of clinical records, facility documentation, facility policies, and resident and staff interviews, for one (1) of 44 sampled residents, the facility's staff failed to prevent and protect Resident #105 from psychological and physical abuse by Employee #5 and because of the Employee's employment history, there is a likelihood of the employee abusing other residents. The findings include: Review of the facility's policy entitled, "Abuse Investigation and Reporting" with a review date of 08/2020 revealed, "... The administrator will ensure that further potential abuse, neglect exploitation or mistreatment is prevented ..." Review of the facility's policy entitled, "Abuse and Neglect- Clinical Protocol" with a review date of 08/2020 revealed, " ... The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect ..."	L 526	**L 521** **To be treated with respect and dignity and assured privacy during treatment and when receiving personal care.** 1. Corrective action for resident Resident #102 has been given a privacy bag. The urine collection bag was measured and emptied. 2. Identify other residents An audit of other residents with urine collection bags did not identify any other residents affected. There were no additional findings related to this citation. 3. Systemic changes Staff have been educated on the importance of	11/02/2021

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L 526	Continued From page 144 Facility staff failed to provide a safe environment to prevent and protect Resident #105 from the likelihood of abuse from Employee #5. Resident #105 was admitted to the facility on 05/26/2021, with multiple diagnoses that included: Polyneuropathy, Anxiety Disorder, Bipolar Disorder, Major Depressive Disorder, and Chronic Pain Syndrome. On 08/19/2021 a complaint was received by the State Agency that documented, "[Resident #105... reported to the Ombudsman... on the night of August 18th [2021] the nursing Aide stuffed [Resident #105's] brief with pieces from a chuck (incontinence pad) and said 'I am not changing you again tonight' ..." Review of a memo from Employee #1 (Administrator) dated 08/24/2021, documented, " ... We interviewed the staff and other residents on the unit (3 west) along with examining the medical chart. The abuse and neglect investigation has concluded, and it was determined from the investigation there was no evidence presented to prove abuse and neglect was committed towards the resident [Resident #105] in question. Therefore, the case has been unsubstantiated due to these findings." On 08/27/2021, a complaint was received by the State Agency that documented, "[Resident name]...The residents daughter reported to the Ombudsman ... C.N.A. (Certified Nurse's Aide) ... told the resident 'she caused him three days of pay, and that she talks too much." Review of Resident #105's Significant Change	L 526	resident's rights to include privacy. The Director of Nursing and Unit Managers will be responsible for validating privacy rounds/inspections and subsequent follow up on findings. 4. Monitor corrective actions The Director of Therapeutic Recreation/Designee will complete audits of 10 resident rooms per week for privacy rounds/inspections to assess compliance and follow up on any subsequent findings. The results will be reported to the QAPI Committee monthly x 3 months for review and recommendations. The QAPI Committee is responsible for the on-going monitoring for compliance. 5. Date correction action completed The facility's date of alleged compliance is November 2, 2021. **L 526** **To keep and use personal clothing and possessions, as space permits, unless to do sowould infringe on other residents' rights or is medically contraindicated** 1. Corrective action for resident Identified resident #105 (no longer resides in the facility) was interviewed 9-8-2021 and signed their statement. The identified Aide was terminated on 9-01-2021. 2. Identify other residents An audit of all other resident's completed.	11/02/2021

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L 526	Continued From page 145 Minimum Data Set (MDS) dated 07/13/2021, revealed that facility staff coded the following: In Section C (Cognitive Patterns), Brief Interview for Mental Status (BIMS) score "15", indicating intact cognitive response. In Section E (Behavior), Hallucinations (perceptual experiences in the absence of real external sensory stimuli) "No"; Delusions (misconceptions or beliefs that are firmly held, contrary to reality) "No"; and in Section GG (Functional Abilities and Goals), Toileting hygiene "... total dependence ... one-person physical assist". During a face-to-face interview conducted on 08/30/2021 at 9:06 AM, Employee #1 (Administrator) stated, "The staff member [Employee #5] and the Nurse Supervisor knew not to assign him to work with the resident (Resident #105). There was obviously a breakdown in the system. The involved CNA was floated to 3 west (where Resident #105 resided). He was not originally assigned to that unit. He [Employee #5] reported that he did not say anything to [Resident #105] while he was providing care. The supervisor is getting reprimanded, and the involved CNA was suspended (on 08/27/2021) and is being terminated as of today." During a face-to-face interview conducted on 08/30/2021 at 9:17 AM with Employee #2 (Director of Nursing), she stated, "We don't tolerate abuse. I do hand-off (transfer of patient care and responsibility from one healthcare provider to another) communication with the supervisors during the week. The supervisors	L 526	There were no additional findings related to this citation. 3. Systemic changes All FRIs from January 2021 to present were reviewed to ensure that they were properly investigated. Education files of any staff involved in the FRIs were reviewed to ensure that appropriate actions were taken regarding their involvement. Education/Designee will in-service all staff on the Abuse Policy and procedures. New Administrator and Governing Board will in-service leadership on the Abuse Policy and procedures. In the future, any employees involved in allegations of abuse, neglect, exploitation, or mistreatment will receive immediate in-servicing on the facility's Abuse Policies and Procedures. All future FRIs/ allegations conclusions will be forwarded by email/writing the LNHA/HR/DON/Departmental Supervisor [Licensed Nursing Home Administrator/Human Resource/Director of Nursing] with the results and preventative measures that have been put in place to protect the resident. 4. Monitor corrective actions Administrator/ Designee will conduct an audit all FRIs weekly for 2 months to ensure the facility has completed a thorough investigation of the alleged violation; prevented further abuse, neglect, exploitation and mistreatment from occurring while the investigation was in progress; and took appropriate corrective action, as a result of investigation findings. Results of finding will be forward to QAPI for review and	

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L 526	Continued From page 146	L 526	recommendations.	

were made aware that the CNA involved was not to work on the third floor at all."

During a telephone interview conducted on 08/30/2021 at 10:36 AM, Employee #6 (Nurse Supervisor) stated, "The CNA [Employee #5] was floated to 3 west because we didn't have a CNA for that unit. I was told that the CNA shouldn't be floated to 3 east. I was not made aware about the issues on 3 west."

During a telephone interview conducted on 08/30/2021 at 10:50 AM, Employee #5 stated, "I was working on 2 East and was pulled to 3 West because they were short. I was told the investigation was resolved and no issues were found, so I went to the unit (3 west). I was taking care of the roommate (room 333 bed B) when [Resident #105] stated that she was wet and needed assistance as well. I reminded her that she made a report on me and that I didn't want any problems. The resident stated that she wanted me to help her and so I did. There were no issues during the ADL (activities of daily living) care. I have been doing this for 17 years. I have never done anything to her nor intimidate her in any way."

Review of Employee #5's personnel file on 09/08/2021 revealed a form entitled; "[Facility's Name] Employee Warning Notice" dated 07/29/2020. The form revealed that Employee #5 received a verbal warning on (07/16/2020) and a written warning on (07/20/2020) for "violation of policy/procedure".

Attached to the previously mentioned warning notice was a document written by the (previous) Director of Nursing that revealed the following:

The QAPI Committee is responsible for the on-going monitoring for compliance.

5. Date correction action completed

The facility's date of alleged compliance is September 15, 2021.

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L 526	Continued From page 147 "On the morning of July16, 2020, it was brought to the attention of the Director of Nursing by Wound Care Team member... a resident [that resided on unit 3 east] was observed with a urine filled incontinence brief on and a urine saturated Ultrasorb (under pads) in the incontinence Brief. CNA (Employee #5) ... was asked about the use of the under pads inside of the resident ' s diaper. [Employee #5] said [Resident's Name] is a heavy wetter..." "On the morning of July 20 [2020] ... [Resident #105] had a urine stained Ultrasorb under pad taped together to form a incontinence brief and was taped to the resident's skin...[Resident 105's roommate] was observed with the same makeshift incontinence brief and in addition urine soaked towel was found between the resident's legs... This is the second occurrence within one week where [Employee #5] provided care to residents in a manner ... The type of care provided by [Employee #5] to the residents is a Type B Offense... Acting in a way that can be considered abuse or neglect, or mistreatment of a patient/resident either physically, mentally or verbally." Review of the investigation notes and documents revealed there was no documented evidence that the facility's staff reviewed Employee #5's personnel record or implemented measures to protect all residents including Resident #105, from the potential of "abuse or neglect, or mistreatment of a patient/resident either physically, mentally or verbally." Additionally, Employee #5's personnel record failed to outline why the employee was not allowed to work on unit 3 East. During a face-to-face interview on 09/08/2021 at	L 526		

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L 526	Continued From page 148 approximately 10:30 AM, Employee #7 (Director of Human Resources) stated, "The previous disciplinary actions (that occurred in 07/2020) were not mentioned to the Director of Nursing until a meeting that occurred on 08/31/2021 when termination (of Employee #5) was discussed." During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #2 (Director of Nursing) stated, "I was not aware of any previous allegations made for Employee #5 (CNA) until the meeting on 08/31/2021." During a face-to-face interview on 09/08/2021 at approximately 10:30 AM, Employee #1 (Administrator) stated, "I was not aware of any previous allegations or disciplinary actions for the employee (Employee #5). I did not review his personnel file as part my investigation."	L 526		