STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. BUILDING ______ B. WING ______	10/13/2020

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F 000 INITIAL COMMENTS — F 000

An unannounced Long Term Care Recertification Survey was conducted at Unique Rehabilitation and Health Center from September 30, 2020 through October 13, 2020. Survey activities consisted of a review of 43 sampled residents. The following deficiencies are based on observation, record review and resident and staff interviews. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The resident census on the first day of survey was 203.

The following is a directory of abbreviations and/or acronyms that may be utilized in the report:

Abbreviations
AMS - Altered Mental Status
ARD - Assessment Reference Date
AV- Arteriovenous
BID - Twice- a-day
B/P - Blood Pressure
BPH- Benign Prostatic Hyperplasia
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

Unique Rehabilitation and Health Center make its best efforts to operate in substantial compliance with both Federal and State Laws.
Submission of this Plan of Correction (POC) does not constitute an admission or agreement by any party, its officers, directors, employees or agents as to the truth of the facts alleged or the validity of the conditions set forth of the statement of deficiencies.
This POC is prepared and/or executed solely because it is required by Federal and State Laws.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: LNHA (X6) DATE: 11/13/2020

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

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F 000	Continued From page 1 Dl- Deciliter DMH - Department of Mental Health DOH- Department of Health DON Director of Nursing DRR Drug Regimen Review EHR Electronic Health Record EKG - Electrocardiogram ER Emergency Room EMS - Emergency Medical Services (911) ESRD- End Stage Renal Disease F - Fahrenheit FR.- French G-tube- Gastrostomy tube HR- Hour HSC - Health Service Center HVAC - Heating ventilation/Air conditioning ID - Intellectual disability IDT - Interdisciplinary team IPCP- Infection Prevention and Control Program LPN- Licensed Practical Nurse L - Liter Lbs - Pounds (unit of mass) MAR - Medication Administration Record MD- Medical Doctor MDS - Minimum Data Set Mg - milligrams (metric system unit of mass) M- minute mL - milliliters (metric system measure of volume) mg/dl - milligrams per deciliter mm/Hg - millimeters of mercury MN- midnight MRR- Medication Regimen Review N/C- Nasal canula Neuro - Neurological NFPA - National Fire Protection Association NP - Nurse Practitioner O2- Oxygen	F 000		

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F 000	Continued From page 2 PASRR - Preadmission screen and Resident Review Peg tube - Percutaneous Endoscopic Gastrostomy PO- by mouth POA - Power of Attorney POC- Plan of Correction PCC Point Click Care POS - physician's order sheet Prn - As needed Pt - Patient PTA- Physical Therapy Assistant Q- Every QIS - Quality Indicator Survey RD- Registered Dietitian RN- Registered Nurse ROM Range of Motion RUE Right Upper Extremities RP R/P - Responsible party SBAR - Situation, Background, Assessment, Recommendation SCC Special Care Center Sol- Solution TAR - Treatment Administration Record TSH- Thyroid Stimulating Hormone TV- Television Ug - Microgram	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		

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F 550	Continued From page 3 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, for one (1) of 43 sampled residents, facility staff failed to treat residents with dignity and respect during dining observations for one (1) resident. Resident #1	F 550	**1. Corrective Action for the resident** **Affected:** Resident #1 was re-assessed on 10/08/2020. Resident #1 suffered no negative outcome from the deficient practice. Employees #6, #13, & #21 were provided re- education on how to ensure dignity and respect for residents during meal time. Employees were in-serviced on the importance of sitting at a face level while assisting residents with feeding. **2. Identification of Others with Potential to be Affected:** All residents residing in the facility have potential to be affected. Nurse managers conducted facility wide audit to ensure that residents that require feeding assistance are treated with dignity and respect during meal time. Identified issues were immediately addressed.	12/11/20

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F 550	Continued From page 4 Findings included... Facility staff failed to treat Resident #1 with dignity and respect during two (2) dining observations. Resident #1 was admitted to the facility on 5/7/2004, with diagnoses that included Hypertension (HTN), Benign Prostatic Hyperplasia (BPH), Diabetes Mellitus (DM), Hyperlipidemia and Non-Alzheimer's Dementia. Review of the Minimum Data Set (MDS) dated 5/4/2020, Section G (Functional Status) indicated Resident #1 required one-person physical assist support while eating. During a tour of unit 2 South on 10/5/2020, at 1:32 PM, Resident #1 was observed seated in bed (a semi-sitting position of 45-60 degrees) being fed by Employee # 6 (unit manager) who was standing. At 1:45 PM, Employee #13 (certified nursing aide), who had taken over for Employee #6, was also observed standing while feeding Resident #1. During a second tour of unit 2 south on 10/8/2020, at approximately 1:30 PM, Employee #21 (certified nursing aide) was also observed standing up while feeding Resident #1. Facility staff failed to provide Resident #1 with dignity and respect during two (2) dining observations.	F 550	**3. Measures to prevent recurrence:** Staff Development Director will educate nursing staff on providing assistance to residents that require one person physical assist support while eating. Education will emphasize on the importance of sitting at face level with residents while providing feeding assistance to ensure residents are assisted with dignity and respect. Assistant Director of Nursing / Designee will conduct rounds during meal time to ensure residents that require physical assistance while eating receive feeding assistance with respect and dignity. **4. Monitoring Corrective Action:** Director of Nursing/Designee will review reports and findings weekly during risk meeting and forwarded to the Quality Assurance Committee monthly x 3.	12/11/20

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F 550	Continued From page 5	F 550		
	During a face-to-face interview conducted on 10/8/2020, at 1:38 PM, Employee #6 stated, "Staff are educated on how to provide dignity when feeding. If anyone is not doing it properly then they must be new." During the interview, Employee #6 acknowledged the findings.			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		
	§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,			

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F 580	Continued From page 6 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 43 sampled residents, facility staff failed to notify the responsible party of Resident #149's refusal to have his weight obtained by staff. Findings included... Resident #149 was admitted to the facility on February 8, 2018, with diagnoses that included Cirrhosis, End Stage Renal Disease (ESRD), Dementia, Seizure Disorder, Asthma and Respiratory Failure. Review of the Quarterly Minimum Data Set (MDS) dated August 17, 2020, showed in Section C (Cognitive Pattern), Resident #149's Brief	F 580	**1. Corrective Action for the residents Affected:** Resident #149 was re-assessed on 10/07/2020 and re-encouraged to be weighed but refused. Resident #149 care plan has been updated on 10/07/2020 with refusal to be weighed. Employees #4 and #11 were counseled regarding failure to notify the responsible party of resident #149's refusal to have his weight obtained by staff. Resident #149 did not suffer any negative Outcome. **2. Identification of others with potential to be affected:** Residents residing in the facility have the potential to be affected. Nurse managers conducted medical record audit to identify residents that have refused care and responsible party/family member needed to be notified. No other residents were identified as being affected.	12/11/20

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F 580	Continued From page 7	F 580		

Interview of Mental Status (BIMS) score was "7", indicating severe cognitive impairment and has a responsible party. The resident's weight was left blank under section K0200 (Height and Weight) on the MDS dated 5/17/20 and 8/17/20.

Review of the Resident's weight record on October 2, 2020, revealed the following:

Date	Weight
2/7/2020	178.4 Lbs [pounds]
1/15/2020	176.1 Lbs
12/9/2019	175.7 Lbs
11/5/2019	173.2 Lbs
10/11/2019	176.4 Lbs
9/13/2019	174.2 Lbs

The aforementioned weight record shows that the resident's last weight was obtained on 2/7/2020.

Review of the progress notes showed the following:

"8/18/2020 at 16:48 [4:48 PM] ...Quarterly Review- Resident's last weight recorded 2/7/2020- 178.4 [pounds]. He has not allowed the staff or this writer to weigh him. Therefore, weight status is undetermined for 30, 90 and 180 days. Resident was again approached today for consent to be weighed, but stated 'that's a stupid question'. He receives regular, regular Texture diet and consumes 50 - 100% of meals per nursing. No pressure wounds cited at this time."

Review of the care plan last updated on August 8, 2020, showed:
"6/1/2020-Resident declines weight monitoring since March 2020."
"8/18/2020- Resident continues to decline weight monitoring despite education."

3. Measures to Prevent Reoccurrence:

Staff Development Director will provide in-service training to inter-disciplinary team members (IDT) regarding facility's policy on notifying responsible party when there is refusal of care related issues or any change in resident condition with emphasis on residents' refusal to be weighed by staff. (Completion date: 12/11/20)
Assistant Director of Nursing/Designee will conduct weekly audit x 4 and monthly x 3 to ensure that residents' responsible parties are notified of care related issues including refusals.
Report will be forwarded to the Director of Nursing.

4. Monitoring Corrective Action:
Director of Nursing will review report and present during weekly risk meeting.
Report will be forwarded Quality Assurance Committee monthly x 3.

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F 580	Continued From page 8 There was no evidence in the clinical record to show that facility staff notified the resident's responsible party of his refusal to have his weight taken since February 2020. During a face-to-face interview conducted on October 7, 2020, at 11:56 AM with Employee #4 and Employee #11, both acknowledged the findings.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584	**1. Corrective action for the resident Affected:** Torn chair in room 415A was immediately disposed and replaced. Resident in room 415A did not suffer any negative outcome. 4-South television room chair identified was removed immediately and replaced with new furniture set on 10/24/2020. Identified bulk trash was removed 10/09/2020. All residents residing in the facility did not suffer any negative outcome.	12/11/20

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F 584 Continued From page 9

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

Based on observations and interview, it was determined that facility staff failed to provide housekeeping services necessary to maintain a safe, clean and comfortable environment, as evidenced by torn chairs in one (1) of 33 resident's rooms and in one (1) of two (2) television (TV) rooms on the fourth floor, and bulk trash that was piled up in an area located next to the parking lot.

Findings included ...

During an environmental walkthrough of the facility on October 2, 2020, between 9:51 AM and 1:00 PM the following were observed:

1. One (1) of one (1) chair in resident room's #415A and one (1) of four (4) chairs in the TV room on 4 South
were torn throughout.

2. Bulk trash such as mattresses, broken medication cart, chairs, sofas, small trash cans,

F 584

2. Identification of others with potential to be affected:

All residents residing in the facility have the potential to be affected. — 12/11/20
Housekeeping Supervisors conducted facility wide round to ensure torn chairs or defective furniture were removed from resident care area and that the environment is free of trash or environmental hazard.
No other issue of torn or defective furniture and environmental hazard were identified.

3. Measures to prevent recurrence:

Facility Operations Director will in-service house-keeping and maintenance staff on the importance of keeping the environment safe, clean, comfortable, homelike and free of hazard.
Assistant Maintenance Director will conduct daily round to ensure there are no torn or defective furniture in resident care area, trash are being picked up weekly or as needed to prevent trash accumulation, and defective or broken furniture / equipment pilling in the parking lot to prevent environmental hazard.
Findings will be reported during daily Directors/Department heads' meeting.

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F 584	Continued From page 10 and different types of defective equipment were stacked on the outside of the building, next to the parking lot and presented an environmental hazard to the community and a harborage site for pests. These findings were acknowledged by Employee #18 on October 2, 2020, at approximately 3:30 PM and/or Employee #1 on October 7, 2020, at approximately 2:15 PM.	F 584	**4. Monitoring corrective action:** Facility Operations Director will submit report of findings monthly x 3 to Quality Assurance Committee.	12/11/20
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622		

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F 622	Continued From page 11 resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or	F 622	**1. Corrective action for the resident Affected:** Resident #196 no longer resides in the facility. Resident #196 was discharged to the community on 8/01/2020. **2. Identification of others with potential To be affected:** All residents residing in the facility have potential to be affected. Director of Social Service completed audit of residents' medical record discharged with look back period of 60 days. No other residents were affected.	12/11/20

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	095036	A. BUILDING ______ B. WING ______	10/13/2020

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F 622	Continued From page 12 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to document pertinent discharge information on the "Interdisciplinary Discharge Summary" form for one (1) of 43 sampled residents, Resident #196. Findings included... "Interdisciplinary Discharge Summary form" - This document provides information to include a post-discharge plan of care that indicates any arrangements made for follow-up care, any post-discharge medical and non-medical services the resident may require once he/she has	F 622	**3. Measures to prevent recurrence:** Staff Development Director will provide education to social service on the importance of documenting residents discharge on the interdisciplinary discharge summary form to ensure that the facility provides transition support for residents to the community. Social Service Director will audit weekly x 4 and monthly x 3 records of resident to be discharged to ensure documentation on IDT discharge summary and validate transition support of residents to the community. Findings will be reported to the Director Of Nursing. **4. Monitoring corrective Action:** Director of Nursing/Designee will present Report of findings weekly during risk Management meeting for review and Forward to Quality Assurance Committee monthly x 3.	12/11/20

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F 622	Continued From page 13	F 622		

transferred to a new setting.

Resident #196 was admitted to the facility on June 22, 2020, with diagnoses that included: Pulmonary Hypertension, Cardiomegaly, Hyperlipidemia, Anemia and Vitamin D Deficiency.

Review of the Minimum Data Set (MDS) dated June 29, 2020, Section C (Cognitive Pattern) showed Resident #196 had a BIMS score of "15", indicating intact cognitive response.

Review of the medical record showed the following:

The Care plan section of the electronic health record initiated on June 23, 2020, and closed on August 7, 2020, was not revised to address person centered discharge goals and interventions.

Nurses Note dated August 1, 2020, at 15:08 [3:08 PM], showed, "Resident was discharged to the community from the unit/facility today 8/1/2020, at 8:00 AM... Resident left the unit/facility with all his personal belongings including all pertinent discharge information and paperwork ..."

Document entitled, "Interdisciplinary Discharge Summary" dated August 1, 2020, showed, "... Ready to discharge home ... reached his maximal potential goals."

During a face-to-face interview conducted on October 9, 2020, at 10:15 AM, Employee #20

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F 622	Continued From page 14 (social worker), stated, "He just needed home health services. I referred him to [name of home health agency]." There is no evidence that facility staff documented that Resident #196 was referred to a home health agency post discharge from the facility to support his transition to the community in the clinical record or on the "Interdisciplinary Discharge Summary" form. During a face-to-face interview on October 9, 2020, at 3:36 PM, Employee #20, acknowledged the findings.	F 622		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview for one (1) of 43 sampled residents, the facility staff failed to code the Minimum Data Set (MDS) to reflect one (1) resident's diagnosis of Malignant Neoplasm of the Prostate, Resident #191. Findings included... Resident #191 was admitted to the facility on August 5, 2019, with diagnoses that included Malignant Neoplasm of the Prostate, Diabetes Mellitus 2, Hypertension, Cerebral Infarction, Gastroesophageal Reflux Disease, Major Depressive Disorder and Anxiety Disorder.	F 641	**1. Corrective action for the resident Affected:** Resident #191 was re-assessed and Medical record review completed 10/10/20. Correction was made to resident #191 MDS to reflect diagnosis of malignant neoplasm of the prostate. Resident #191 did not suffer any negative Outcome.	12/11/20

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F 641	Continued From page 15 A review of Resident #191's quarterly MDS dated August 20, 2020, and significant change MDS dated September 1, 2020, showed no documentation of the resident's type of cancer diagnosis [Malignant Neoplasm of the Prostate] in Section I (Active Diagnosis), under "Other" I8000 (additional active diagnoses). The evidence showed that the facility staff failed to code the MDS to reflect that Resident #191 had a diagnosis of Malignant Neoplasm of the prostate. During a face-to-face interview with Employee #2 (DON) on October 9, 2020, at approximately 1:15 PM, the employee acknowledged the findings.	F 641	**2. Identification of others with potential To be affected:** All residents residing in the facility have potential to be affected. MDS Coordinators completed review on 11/12/2020 of residents' diagnosis sheet to ensure residents' medical diagnosis are accurately coded and reflect residents' medical status. Nurse managers reviewed residents' medical record for accuracy of residents' diagnosis sheet. No other residents were identified. **3. Measures to prevent recurrence:** MDS regional consultant will provide education to facility MDS coordinators on accurate completion of residents' MDS to reflect active status and all documented diagnosis in residents' medical record including the diagnosis sheet. MDS Coordinators will review residents' Diagnoses sheet weekly x 4 and monthly x 3 to ensure MDS reflects all diagnosis listed in residents' medical records and diagnosis sheet. Findings will be presented to the Director of Nursing. **4. Monitoring Corrective action:** Director of Nursing/Designee will review and present finding during weekly risk management meeting. Report will be forwarded to Quality Assurance Committee monthly x 3.	12/11/20
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		

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F 656	Continued From page 16 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, facility staff failed to develop and implement a comprehensive person-centered care plan with goals and approaches to address the monitoring and side effects of Trazadone (antidepressant and sedative) for one (1) of 43 sampled residents, Resident #178. Findings included ... Resident #178 was admitted to the facility on 9/17/2019, with diagnoses that included Cancer, Orthostatic Hypotension, Benign Prostatic	F 656	**1. Corrective action for the Resident Affected:** Resident #178 was re-assessed on 10/09/2020. Resident #178 comprehensive care plan was revised to include goal and approaches addressing diagnosis of depression including side effects monitoring. Resident #178 did not suffer any negative outcome. **2. Identification of others with potential to be affected:** All residents have the potential to be Affected. Nurse managers completed review of residents' with diagnosis of depression medical records to ensure corresponding care plan reflecting goals, approaches and monitoring of side effects. No other residents were affected by this deficient practice. **3. Measures to prevent recurrence:** Staff Development Director will in-service interdisciplinary team members to ensure residents' care plans are person-centered with goals and interventions addressing resident's diagnosis. Nurse managers will conduct weekly audit x4, monthly x 3. Audit findings will be submitted to the Director of Nursing for review.	12/11/20

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F 656	Continued From page 17 Hyperplasia (BPH), Hyperlipidemia, Rètention of Urine and Depression. Review of the Nurse Practitioner's progress note dated 6/29/2020, at 13:36 (1:36 PM), showed, "Psych Consult: Insomnia... Diagnosis: Axis1: Adjustment d/o (disorder) with depressed mood, Insomnia. Plan: Start Trazodone 50mg (milligrams) po (by mouth) qhs (every night). Monitor Mood and Behavior". A review of the physician's order dated 6/29/2020, showed active diagnosis of "Major Depressive Disorder, Recurrent Unspecified"; an order for, "[Trazadone] HCl (Hydrochloride) tablet 50 MG (milligram) give 50 mg by mouth in the evening for Depression/insomnia Monitor for SI (suicidal ideation)". Further review of the physician's order showed a "Black Box" pharmacy warning (are required by the U.S. Food and Drug Administration for certain medications that carry serious safety risks) stipulated, "Closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors". Review of the care plan section of the clinical record failed to show the development of a person-centered care plan with goals and approaches to address the resident's new diagnosis (depression), the monitoring of side effects such as suicidal ideation, lack of sleeping, worsening depression; and the monitoring for adverse interactions such as, dizziness, nervousness or anxiety for Resident # 178 who was prescribed a new medication (Trazadone).	F 656	**4. Monitoring to prevent recurrence:** Director of Nursing / Designee will review reports during weekly risk meeting to ensure compliance greater or equal to 95% has been achieved. Reports of finding will be submitted to Quality Assurance Committee monthly x 3.	12/11/20

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F 656	Continued From page 18 During a face-to-face interview on 10/8/2020, at approximately 1:25 PM, Employee #6 (unit manager), stated, "I update the care plan as needed and during IDT (interdisciplinary team) meetings. Any new diagnosis, medications-I will make the update." Employee #6 acknowledged the findings.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	**1. Corrective action for the residents affected:** Resident #11 was reassessed on 10/10/2020. Care plan was updated to 10/10/2020. Resident #11 did not suffer any negative outcome. Residents #61 and #158 were reassessed on 10/10/2020. Care plans of residents #61 and #158 were revised and updated on 10/10/2020. Residents #61 and #158 did not suffer any negative outcome. Resident #114 was reassessed on 10/10/2020. Care plan was revised and updated on 10/10/2020. Resident #114 did not suffer any negative Outcome. Resident #149 was reassessed on 10/10/2020. Care plan was revised and updated on 10/10/2020. Resident #149 did not suffer any negative Outcome.	12/11/20

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F 657	Continued From page 19 by: Based on record reviews and staff interviews for five (5) of 43 sampled residents, facility staff failed to update the care plan with goals and approaches to address one (1) resident who had an accident with injury, to address the removal of the protective dressing of graft/fistula site post dialysis for two (2) residents; to address the use of the wound vacuum-assisted closure (VAC) for one (1) resident, and for one (1) residents refusal to have his weight obtained. Residents' #11, #61, #114, #149 and #158. Findings included... 1. Facility staff failed to update the care plan to reflect Resident #11's accident with injury. Resident #11 was admitted to the facility on November 4, 2016, with diagnoses that included Osteoporosis, Parkinson Disease, Hypertension, Encephalopathy, Dysphagia, Major Depressive Disorder, Bipolar Disorder, and Schizophrenia. A review of the progress note dated May 5, 2020, at 5:53PM showed, "At approximately 4:55PM writer was called to report to 3 south to assess this resident. Resident was noted to have a minor cut at the bridge of his nose and 2 minor crates [scrapes] on the fore head. ...staff assisting resident said that he was assisting resident to the chair and while he was still holding him, he hit is head at the counter in the nurses' station. Resident did not fall, the staff held him when this incident occurred." A review of the care plan on October 7, 2020	F 657	**2. Identification of others with potential to be affected:** All residents residing in the facility have the potential to be affected. Nurse Managers completed audits of residents medical records to ensure that care plan of residents with documented incident / accident reflects and address accurately the documented incident. No other residents were identified. Nurse managers completed audits of care plans of residents receiving dialysis to ensure that care plans address removal of protective dressing of graft/fistula site post dialysis as ordered by physician. No other residents were identified. Nurse managers completed audit on medical record of residents with the use of wound vacuum assisted closure to ensure that care plans reflect person-centered goals and approaches including instructions specific to physician order for use of the wound vac. No other residents were identified. Nurse managers completed audit of residents' medical records to ensure care plans of residents refusing care are updated to reflect and address approaches to obtain weight. No other residents were identified.	12/11/20

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F 657	Continued From page 20 showed that facility staff failed to update Resident #11's care plan to reflect the accident with injury that occurred on May 5, 2020 and there were no revisions with person-centered goals and approaches to address the residents accident with injury. During a face-to-face interview conducted on October 9, 2020, at approximately 1:15 PM with Employee #2 (DON). She acknowledged the findings. 2. Facility staff failed to update Resident #61's care plan to reflect the removal of the protective dressing of graft/fistula site post dialysis. A review of the Policy and Procedure document entitled "Hemodialysis" Revised 07/02/2020 showed "5. The facility licensed nurses will be responsible for removing the protective dressing of graft/fistula site after 4 hours of resident return from dialysis." Resident #61 was admitted to the facility on July 22, 2016, with diagnoses to include End-stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, and Anemia A review of a Physician's order dated September 29, 2020 showed "Resident is Dialysis days are Monday, Wednesday and Friday at 3pm at [name] Dialysis Center ... 3 times a week every Mon, Wed, Sat [Friday] for dialysis." A review of the Progress notes dated September 1, 2020 through October 9, 2020 [17 days] showed that Resident #61's protective dressing was removed from the access site 6 days out of	F 657	**3. Measures to prevent Reoccurrence:** Staff Development Director will provide in-service to interdisciplinary team members on the importance of updating care plans and consistent documentation reflecting person-centered goals and approaches to address incident, refusal of care, post dialysis fistula/graft removal, and use of wound vac. Nurse Managers will conduct weekly audit x 4 weeks, and monthly x 3. Audit findings will be submitted to Director of Nursing for review.	12/11/20

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F 657	Continued From page 21 the 17 dialysis days reviewed. A review of the care plan on October 9, 2020 showed that facility staff did not update Resident #61's care plan to reflect the removal of the resident's protective dressing from the access site post dialysis. During a face-to-face interview conducted on October 9, 2020, at approximately 1:15 PM with Employee#2 (DON). She acknowledged the findings. 3. The facility staff failed to update Resident #114's care plan with person centered goals and approaches to address use of the wound vacuum-assisted closure (VAC) (a method of decreasing air pressure around a wound to assist the healing). Resident #114 was admitted to the facility on November 15, 2019 with diagnoses that included: Anemia, Hypertension (HTN), Diabetes Mellitus, Thyroid Disorder, Osteoporosis, Encephalopathy and Sacral Pressure Ulcer. The physician's order dated July 27, 2020, directed, "Sacralgluteal Wound - Cleanse with daikins solution and apply Negative Pressure Wound Treatment (Wound vac for 72hours) on Mondays." Review of the Resident's focus care plan last reviewed by facility's interdisciplinary team (IDT) on September 24, 2020, showed, "Sacral pressure ulcer stage 4 ...is on a wound vac ... Care plan goals reviewed and updated. Current POC (plan of care) continues".	F 657	**4. Monitoring Corrective Action:** Director of Nursing/Designee will review report during weekly risk meeting to ensure greater than or equal to 95% compliance and forward monthly x 3 to Quality Assurance Committee.	12/11/20

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F 657 — F 657

Continued From page 22

The interventions listed on the care plan were not person-centered to include instructions specific to the physician's order for use of the wound vac as referenced above.

During a face-to-face meeting on October 9, 2020, at 10:47 AM the Employee #4, unit manager acknowledged the findings.

4. Facility staff failed to revise the care plan for Resident #149 with person centered goals and approaches to address his refusal to have his weight obtained.

Resident #149 was admitted to the facility on February 8, 2018, with diagnoses that includes: Cirrhosis, End Stage Renal Disease (ESRD), Dementia, Seizure Disorder, Asthma and Respiratory Failure. On the Quarterly Minimum Data Set (MDS) dated August 17, 2020, the residents Brief Interview of Mental Status (BIMS) score was "7" indicating that he has severe cognitive impairment.

Review of this weight record on October 2, 2020, revealed the following:

2/7/2020	178.4 Lbs [pounds]
1/15/2020	176.1 Lbs
12/9/2019	175.7 Lbs
11/5/2019	173.2 Lbs
10/11/2019	176.4 Lbs
9/13/2019	174.2 Lbs

Review of the progress notes showed the following:

"8/18/2020 at 16:48 [4:48 PM] Quarterly Review - Resident's last weight recorded 2/7/2020-

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F 657	Continued From page 23	F 657		

178.4[pounds]. He has not allowed the staff or this writer to weigh him. Therefore, weight status is undetermined for 30, 90 and 180 days. Resident was again approached today for consent to be weighed, but stated 'that's a stupid question'. He receives Regular, regular Texture diet and consumes 50 - 100% of meals per nursing. No pressure wounds cited at this time."

Review of the care plan revised on August 8, 2020, showed:

"Potential/Alteration in Nutritional status r/t (related to) h/o (history of) Cirrhosis, Anemia, Hx (history). Malnutrition; Dementia; Meds"
6/1/2020-Resident declines weight monitoring since March 2020.
8/18/2020- Resident continues to decline weight monitoring despite education.
[Resident #149] is at risk for a behavior problem (agitation) r/t history of agitation and diagnosis of dementia with behavioral disturbance".

The interventions listed on the care plan were not person-centered to include approaches to obtain the residents weight.

During a face-to-face interview October 7, 2020, at 11:56 AM, Employee #4 acknowledged the findings.

5. Facility staff failed to update Resident #158's care plan to reflect the removal of the protective dressing of graft/fistula site post dialysis.

A review of the Policy and Procedure entitled "Hemodialysis" Revised 07/02/2020 showed "5.

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F 657	Continued From page 24 The facility licensed nurses will be responsible for removing the protective dressing of graft/fistula site after 4 hours of resident return from dialysis." Resident #158 was admitted to the facility on November 21, 2014, with diagnoses to include Anemia, Hypertension End stage Renal Disease, Dependence on Renal Dialysis, Diabetes Mellitus. A review of a Physician's order dated September 17, 2020, showed "Resident is on Dialysis, Hemodialysis on Tues [Tuesday], Thurs [Thursday], and Sat [Saturday] at [Hospital name] outpatient every day shift [Tuesday], [Thursday], [Saturday] for Dialysis." A review of the Progress note dated September 1, 2020 through October 9, 2020 [16 days] showed the dressings to the resident's left AV [Arteriovenous] graft access site was intact on 2 dialysis days. However, there was no documented record in the progress note to show that the resident's protective dressing was removed from the access site on any of the 16 days reviewed. A review of care plan on October 9, 2020, showed that facility staff did not update Resident #158's care plan to reflect the removal of the resident's protective dressing from the access site post dialysis. During a face-to-face interview conducted on October 9, 2020, at approximately 1:15 PM with Employee #2 (DON). She acknowledged the findings.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI	F 690		

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F 690	Continued From page 25 CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 690	**1. Corrective action for the resident Affected:** Residents #35 and #178 were re-assessed on 10/08/2020. Urinary drainage bags were replaced with leg bags and secured with leg straps on both residents to prevent trauma and ensure catheter tubing placed below the bladder to prevent back flow and infection. Residents #35 and #178 did not suffer any negative outcome. Employees #14 and #6 were both provided with counselling by the nurse manager on 10/08/2020 on the importance of securing urinary drainage catheter, placing urinary bag below bladder to prevent backflow, and use of leg bag to ensure residents' privacy and dignity.	12/11/20

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F 690	Continued From page 26 interview, facility staff failed to secure the indwelling catheter tubing and failed to maintain urinary catheter drainage systems below the level of the bladder for two (2) of 43 sampled residents. Residents' #35 and Resident #178. Findings included... A review of the facility's policy entitled, "Urinary Catheterization/Foley Care" dated 7/15/2020, showed, " ...Indwelling catheters should be properly secured after insertion to prevent movement and urethral trauma... Drainage bags should always be placed below the level of the patient's bladder to facilitate drainage [allows the urine to drain by gravity and prevents it from flowing back into the bladder] and prevent stasis of urine." According to Cleveland Clinic " ...Always keep your urine bag below your bladder, which is at the level of your waist. This will prevent urine from flowing back into your bladder from the tubing and urine bag, which could cause an infection." https://my.clevelandclinic.org/health/articles/14832-urine-drainage-bag-and-leg-bag-care 1. Resident #35 was admitted to the facility on 12/20/2019, with diagnoses that included Neuralgia, BPH (Benign Prostatic Hyperplasia), Muscle weakness and Neuritis. Review of the Quarterly Minimum Data Set (MDS) dated 6/27/2020, Section G (functional status), showed Resident #35 coded as "extensive assistance" for self-performance, indicating that resident required one-person	F 690	**2. Identification of others with potential To be affected:** Facility residents with the use of urinary Catheter have potential to be affected. Nurse managers completed audit of residents with the use of urinary catheter on 10/08/2020 to ensure that identified resident have catheter secured to the leg with strap to prevent trauma and back flow and use of a leg bag for privacy and dignity. No other residents were identified.	12/11/20

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F 690	Continued From page 27 physical assist for dressing and toilet use. Under Section H (Bladder and Bowel), the resident was coded as having an indwelling catheter. During a tour of unit 2 south on 10/8/2020, at approximately 1:30 PM, Resident #35 was observed with urinary catheter tubing visible outside of pants, tubing coming from waist band (above the bladder) with bedside drainage bag hooked to wheelchair. Review of the physician's order dated 1/13/2020, at 23:00 [11:00 PM] showed, "Check catheter and tubing for kink every shift ... for Urinary retention". Further review of the care plan dated 7/27/2020, showed, " ...Catheter: Position catheter bag and tubing below the level of the bladder and away from entrance room door .... Check tubing for kinks each shift ..." During a face-to-face interview conducted on 10/8/2020, at 1:38 PM, Employee #14 (certified nursing assistant, CNA), stated, "I got [Resident #35] dressed this morning. Yes, I know to secure the tubing. I am going to get a leg strap [provides privacy, prevents tubing from catching or pulling from regular movements] once I finish feeding this resident." Employee #14 (CNA), acknowledged catheter was inappropriately placed. Facility staff failed to keep the urinary catheter tubing secured on the resident to prevent urethral trauma and failed to ensure the catheter tubing was placed below the bladder to prevent the back flow of urine into the bladder of Resident #35.	F 690	3. **Measures to prevent recurrence:** Staff Development Director will provide education to nursing staff on urinary catheter and care. Training will focus on the importance of placing drainage bags below the level of residents'' bladder to facilitate drainage and prevent back flow or infection. Staff Development Director will also train on the importance of securing the tubing catheter to the leg to prevent trauma with the use of leg bag to ensure residents dignity and privacy. Assistant Director of Nursing/Designee will conduct daily round on residents with the urinary catheter to ensure that catheters are secured, urinary bags are placed below the bladder, and leg bags are being used to ensure residents' privacy and dignity when leaving the unit. Findings will be submitted to the Director Of Nursing weekly x 4 and monthly x 3 for review.	12/11/20

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F 690	Continued From page 28 During a face-to-face interview conducted on 10/8/2020, at 1:45 PM, Employee #6 (unit manager), stated, "Staff receive in-service on catheter care and dignity. I already talked to the CNA (Employee #14) this morning about securing the catheter and the leg strap, we are getting the leg strap now." Employee #6 (unit manager), acknowledged the findings. 2. Resident #178 was admitted to the facility on 9/17/2019, with diagnoses that included Cancer, Orthostatic Hypotension, BPH, Hyperlipidemia, Retention of Urine and Depression. Review of the MDS dated 8/26/2020, showed in Section G (functional status), Resident #178 is coded as "extensive assistance" for self-performance, indicating that resident required one-person physical assist for dressing and toilet use. Under Section H (Bladder and Bowel), the resident was coded as having an indwelling catheter. During a tour of unit 2 south on 10/6/2020, at 11:04 AM, Resident #178 was observed ambulating on the unit with urinary catheter tubing visible outside of pants, tubing coming from waist band (above the bladder) with bedside drainage bag hooked to walker. Review of the physician's order dated 1/13/2020, at 23:00 (11:00 PM) showed, "Check catheter and tubing for kink every shift ... for Urinary retention". Facility staff failed to keep the urinary catheter tubing secured on the resident to prevent urethral trauma and failed to ensure the catheter tubing	F 690	**4. Monitoring corrective action:** The Director of Nursing/Designee will present report weekly during risk management meeting and forward to Quality Assurance Committee monthly x 3.	12/11/20

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F 690	Continued From page 29 was placed below the bladder to prevent the back flow of urine into the bladder for Resident #178. During a face-to-face interview conducted on 10/6/2020, at approximately 11:15 AM, Employee #6 (unit manager), stated, "I am sending the nurse down now to get a leg strap and drainage bag." Employee #6, acknowledged the findings.	F 690	**1. Corrective action for the resident Affected:** Resident #244 was re-evaluated by the Clinical team on 10/05/20.	12/11/20
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews for one (1) of 43 sampled residents, the facility staff failed to accurately assess Resident # 244's colostomy site in her progress note. Findings included... Resident #244 was admitted on September 28, 2020, with diagnoses that included Diverticulitis of Intestine, Secondary Hypertension, Peripheral Vascular Disease (PVD), Colostomy Status and Muscle Weakness. A face-to-face interview with Resident #244 was	F 691	Use of condom catheter was ordered on 10/05/2020 per resident request. Use of condom catheter was updated into resident #244 care plan. Employee #19 was counselled by the Director of Nursing on the importance of accurate assessment to facilitate correct documentation. Resident # 244 did not suffer any negative outcome. **2. Identification of others with potential To be affected:** All residents residing in the facility have potential to be affected. Nurse managers conducted audit of residents medical records to identify other residents requesting the use of condom catheter or with history of use. No other residents were identified.	

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F 691	Continued From page 30	F 691		

conducted on October 5, 2020, at approximately 2:00 PM. Resident #244 was asked about his condom catheter. Resident #244 explained that he had a condom catheter on admission but it was removed on Friday morning (October 5, 2020) and was told that it would be replaced on Friday afternoon but it was not.

Review of the progress notes showed:

9/29/2020, at 19:00 [7:00 PM], "Resident is incontinent of both bowel and bladder; has a colostomy bag and uses an [adult brief]..."

9/29/2020, at 23:18 [11:18 PM], "Resident is alert and verbally responsive...Bowel sound present in all four quadrants...the condom catheter intact and draining clear yellow urine. The urine measure 620ml (milliliters) during this shift. Safety measure maintain and call light within reach. [vital signs] BP (blood pressure) 136/70, T (temperature) 97.7, P (pulse) 80, R (respiration) 18, SPO2 (oxygen saturation) 98% room air. "

During a face-to-face interview conducted on 10/6/2020 at 3:23 PM Employee #19 (Registered Nurse), stated, "It was wrong documentation. I was the only nurse on the floor for the evening shift and I had one CNA. I was talking about the colostomy not a condom catheter. No resident on the unit had a condom catheter. It is the wrong documentation."

There was no evidence that Employee #19 recorded her assessment of the resident's colostomy site (located in an area of the abdominal quadrants and drains effluent). Her assessment of the colostomy may have included

3. **Measures to prevent recurrence:**

Staff Development Director will provide education to licensed nursing staff on accurate assessments. Training will focus on differences between colostomy and urine catheter to foster accuracy of documentation. Specific characteristics such as amount, consistency, overall appearance of the content, skin around the stoma, and pouch leakage will be included to identify colostomy documentation. Urine amount, color of the urine drainage, and position of catheter bag below the bladder will be specific characteristics to catheter usage and documentation. — 12/11/20

Assistant Director of Nursing / Designee will review clinical record including admission and re-admission profile during daily clinical ground round to ensure that residents with use or history of use of condom catheter and other medical appliances are clarified with physicians and residents to ensure continuity of use where it's determined to support residents psychosocial well being.

Audit findings will be forwarded to the Director of Nursing weekly x 4 and monthly x 3 for review.

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F 691	Continued From page 31 characteristics such as the amount, consistency, the overall appearance of the content in the effluent (i.e. liquid, formed, soft, thin, or tarry), the skin around the stoma, pouch leakage and signs of infection. Instead, Employee #19 recorded an assessment of a condom catheter (applied to the genitals of a resident) that she stated was not present or in place on the resident. During a face-to-face interview conducted with Employee #2 (Director of Nursing) on October 6, 2020, at 3:27 PM, the Employee acknowledged the findings.	F 691	**4.Monitoring corrective action:** The Director of Nursing / Designee will review and present report of findings during weekly risk management meetings. Report will be submitted to Quality Assurance Committee monthly x 3.	12/11/20
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		

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F 756	Continued From page 32 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for two (2) of 43 sampled residents, facility staff failed to minimize potential adverse consequences related to medication therapy for one (1) resident on two occasions and failed to maintain the pharmacy drug regimen review on the active record for one (1) resident. Residents' # 50 and #172. Findings included.... 1A. Facility staff failed to minimize potential adverse consequences related to medication therapy for Resident #50 who had an elevated thyroid stimulating hormone (TSH) level. Resident #50 was admitted to the facility on 9/26/2019, with diagnoses that included Anemia, Heart Failure, Hypertension (HTN), Renal	F 756	**1. Corrective action for the residents affected:** Resident #50 was re-assessed. TSH level ordered and to be repeated every 3 months. EKG ordered to be done for baseline and every 6 months. Result of the TSH level and EKG have been reviewed by physician to be within normal limit with no new order. Resident #50 did not suffer any negative outcome. Resident #172 pharmacy drug regimen review was completed by pharmacist consultant for November without new recommendations. All pharmacy drug regimen monthly review have been made available in resident medical record. Resident #172 did not suffer any negative outcome.	12/11/20

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Insufficiency, Schizophrenia, Hypothyroidism and Depression.

Laboratory test results showed the following:

"Date of test: 02/03/20 Type of test: TSH 16.321(H) [high] (normal range 0.350-4.940)."
"Date of test: 02/04/20 Type of test: TSH 15.512(H) (normal range: 0.350-4.940) ulU [International Units]/mL [milliliters]."

A review of the physician's order dated 2/26/2020, at 5:21 [AM] showed, "Levothyroxine Sodium Tablet 200 MCG (micrograms) Give 1 tablet by mouth in the morning for [Hypothyroidism]".

A review of the document entitled, "Consultant Pharmacist's Medication Review" dated 3/1/2020 "For Recommendations Created Between 2/1/2020 And 2/29/2020" showed on page 6, " ... [Resident #50] is ordered Levoxyl 150 mcg daily for hypothyroidism. His recent TSH was still elevated at 15.15. Please consider increasing the Levoxyl dose to 175 mcg daily at 0600 (6:00 AM) for [Hypothyroidism] and a follow-up TSH in 6-8 weeks."

In addition, subsequent review showed Consultant #1 (pharmacist) documented on the "Pharmacy Drug Regimen Review" on dates 6/9/2020, 7/11/2020, 8/7/7/2020, and 9/8/2020, "No clinically significant medication issues were identified during the drug regimen review."

There was no evidence that Consultant #1 followed up on the irregularity that was identified on 3/1/2020.

During a telephone interview conducted on

2. Identification of others with potential to be affected:

All residents residing in the facility have potential to be affected.

Nurse managers conducted facility wide audit on residents receiving therapeutic regimen requiring Thyroid Stimulating Hormone (TSH) level monitoring with 90 day look back to ensure that abnormal TSH results are addressed by physicians. No other residents were identified as being affected. — 12/11/20

Nurse managers audited residents' medical records for pharmacy warning label to ensure that they are being addressed by physicians, and residents receiving anti-psychotic with cardiac related diagnosis have EKG baseline and routine monitoring.
No other residents were identified as being affected.

Nurse managers completed audit of Residents' medical records to ensure residents monthly pharmacy drug regimen is completed and available in residents active medical records.
No other residents were identified as being affected.

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F 756	Continued From page 34 10/6/2020, at 12:12 PM, Consultant #1 stated, "Resident's TSH levels have been hard to regulate. I asked for follow-up labs 6-8 weeks in February." During a telephone interview conducted on 10/6/2020, at 1:19 PM, Employee #16 (medical doctor), stated, "We should have repeated another TSH level. The patient has been difficult to regulate due to underlying disease. Will order follow-up lab." Facility staff failed to act on elevated TSH level since February 2020 for Resident #50. 1B. Facility staff also failed to minimize potential adverse consequences related to medication therapy for Resident #50 who receives Haloperidol and Seroquel (both antipsychotic medications used to treat Schizophrenia). Review of the physician's order for Resident #50 showed, "Haloperidol Tablet 5 MG ... Give 1 tablet by mouth at bedtime for Schizoaffective disorder... Start date 7/26/2020". "Seroquel Tablet 50 mg ... Give 1 tablet by mouth at bedtime for Schizoaffective disorder.... Start date 7/26/2020". The pharmacy warning label proceeding the order for Haloperidol indicated, "... increase QT interval (the time from the start of the Q wave to the end of the T wave) with Seroquel". Review of the medical record lacked evidence of monitoring of the resident's QT interval from 7/26/2020.	F 756	**3. Measures to prevent recurrence:** Medical director will provide education to physicians and facility pharmacy consultant on timely, consistent, and appropriate follow up with resident medical records, including abnormal lab value results and completion of monthly pharmacy drug regimen for residents to include evidence of completion by making recommendations available in resident active medical records. Nurse managers will audit residents' medical records daily during clinical round to ensure that; abnormal lab results have been addressed by physicians, pharmacy warning labels are reviewed, monthly pharmacy drug regimen for residents are completed and available in residents' active medical records. Findings will be submitted to the Director of Nursing weekly x 4 and monthly x 3.	12/11/20

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	095036	A. BUILDING ______ B. WING ______	10/13/2020

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F 756	Continued From page 35 During a telephone interview conducted on 10/6/2020, at 12:12 PM, Consultant #1 stated, "A baseline EKG (electrocardiogram) not required based on my clinical pharmacy resource. Resident is not at risk; he doesn't have history of heart issues. I did not make the recommendation." However, review of the diagnoses listed in the MDS dated 7/1/2020, indicated resident does have history of heart disease. During a telephone interview conducted on 10/6/2020, at 1:19 PM, Employee #16, stated, "EKG should have been done. Will follow-up and get one." Facility staff failed to obtain a baseline electrocardiogram (EKG) for Resident #50 who was prescribed medications that have increase risk for QT interval prolongation. During telephone interviews conducted on 10/16/2020, both Consultant #1 and Employee #16, acknowledged the findings. 2. Facility staff failed to maintain the Pharmacy drug regimen review on the active record for Resident #172. Resident #172 was admitted to the facility on October 14, 2011, with diagnoses to include Diabetes Mellitus 2, Hypertension, Hyperlipidemia, Cataract, Hyperkalemia, Hypothyroidism impulse disorder Alzheimer's disease, Peripheral vascular disease, and Osteoarthritis.	F 756	**4. Monitoring corrective action:** Director of Nursing / Designee will review report and present weekly during risk management meetings. Report will be forwarded to Quality Assurance Committee monthly x 3.	12/11/20

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F 756	Continued From page 36 A review of the Assessment section and the Miscellaneous section record in EHR (electronic health record) on 10/9/20 showed the Pharmacy Drug Regimen Review information was not available. There was no evidence that Resident #172's record was reviewed at least once a month by a licensed pharmacist from January 2020, to May 2020 [5 months]. During a face-to-face interview conducted on October 13, 2020, at approximately 10:15 AM with Employee #2. The employee acknowledged the findings, and stated, "They were not place in the PCC [Point click care] system."	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 758		

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F 758	Continued From page 37	F 758		
	§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, for one (1) of 43 sampled residents, facility staff failed to adequately monitor Resident #178 for efficacy and adverse consequences who was prescribed Trazadone Hydrochloride (antidepressant and sedative). Findings included ...		**1. Corrective action for the resident Affected:** Resident #178 was re-assessed by the physician on 10/13/2020. Resident #178 is stable and did not suffer any negative outcome. **2. Identification of others with potential to be affected:** All residents residing in the facility have the potential to be affected. Nurse managers completed audit of residents receiving anti-depressant to ensure that medication with "black box" pharmacy warning displayed in Point Click Care(PCC) / Electronic Medication Administration Record (EMAR) were addressed by physician and have person-centered care plans reflecting goals, and approaches as evidence of adequate monitoring for efficacy and adverse consequences. No other residents were identified as being Affected.	12/11/20

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F 758	Continued From page 38	F 758		

Continued From page 38

Resident #178 was admitted to the facility on 9/17/2019, with diagnoses that included Cancer, Orthostatic Hypotension, Benign Prostatic Hyperplasia (BPH), Hyperlipidemia, Retention of Urine and Depression.

Review of the Nurse Practitioner's progress note dated 6/29/2020, at 13:36 (1:36 PM), showed, "Psych Consult: Insomnia... Diagnosis: Axis1: Adjustment d/o (disorder) with depressed mood, Insomnia. Plan: Start Trazodone 50mg (milligrams) po (by mouth) qhs (every night). Monitor Mood and Behavior".

A review of the physician's order dated 6/29/2020, showed, active diagnosis of "Major Depressive Disorder, Recurrent Unspecified"; Trazadone Hydrochloride tablet 50 mg (milligram) Give 50 mg by mouth in the evening for Depression/insomnia Monitor for SI (suicidal ideation)".

Review of the Medication Administration Record from June 2020, through October 13, 2020, showed that Resident #178 received the Trazadone as ordered by the physician.

Further review showed the "Black box" pharmacy warning (are required by the U.S. Food and Drug Administration for certain medications that carry serious safety risks) stipulated, "Closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors".

Review of the psychiatry follow-up notes dated 8/29/2020, and 9/18/2020, showed, " ... Monitor mood and behavior."

3. Measures to prevent recurrence:

Staff Development Director will in-service licensed nursing staff and interdisciplinary team members on ensuring that residents receiving antidepressant including Trazadone have person-centered care plans and on the importance of reviewing the "black box" pharmacy warning label when displayed in Point Click Care / Electronic Medication Administrative Record to validate medication monitoring for efficacy, and adverse consequences. — Completion date: 12/11/20

Assistant Director of Nursing / Designee will review medical records of residents receiving Trazadone or anti-depressant weekly x 4,then monthly x 3 to ensure person-centered care plans, and that "black box" pharmacy warning has been reviewed and addressed.

Findings will be submitted to the Director of Nursing/Designee.

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F 758	Continued From page 39 Review of the medical record from June 2020, through October 13, 2020, lacked evidence that staff adequately monitored for efficacy and adverse consequences, such as suicidal ideation, lack of sleeping, worsening depression and for adverse interactions such as, dizziness, nervousness, anxiety, for Resident #178, who was prescribed Trazadone on 6/29/2020. In addition, there was no person centered care plan developed with goals and approaches to address the new diagnosis (depression) and monitoring of side effects for a new medication (Trazadone) for Resident #178. During a telephone interview conducted on 10/29/2020, at approximately 3:15 PM, Employee #2 stated, "[Resident #178] does not have any behavioral monitoring notes. There's no reason that requires us to monitor his behavior." Employee #2 acknowledged the findings.	F 758	**4. Monitoring corrective action:** Director of Nursing / Designee will review and present report weekly during risk management meeting. Report will be forwarded to Quality Assurance Committee monthly x 3.	12/11/20
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.	F 773		

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F 773	Continued From page 40 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the attending physician failed to act upon abnormal lab results in a timely manner for one (1) of 43 sampled residents, Resident #50. Findings included... Resident #50 was admitted to the facility on 9/26/2019, with diagnoses that included Anemia, Heart Failure, Hypertension (HTN), Renal Insufficiency, Schizophrenia, Hypothyroidism and Depression. Laboratory test results showed the following: "Date of test: 02/03/20 Type of test: TSH [Thyroid-stimulating hormone] 16.321(H) [high] (normal range 0.350-4.940)." "Date of test: 02/04/20 Type of test: TSH 15.512(H) (normal range: 0.350-4.940) ulU (International Units)/mL (milliliters)." A review of the physician's order dated 2/26/2020 at 5:21 [AM] showed, "Levothyroxine Sodium Tablet 200 MCG (micrograms) Give 1 tablet by mouth in the morning for [Hypothyroidism]". A review of the document entitled "Consultant Pharmacist's Medication Review" dated 3/1/2020, "For Recommendations Created Between 2/1/2020 And 2/29/2020" showed on page 6, " ... [Resident #50] is ordered Levoxyl 150 mcg daily for hypothyroidism. His recent TSH was still	F 773	**1. Corrective action for the resident Affected:** Resident #50 was re-assessed by clinical team on 10/11/2020. Result of the newly ordered TSH level was received and reviewed by physician. Result is within normal value range with no new order. Resident #50 did not suffer any negative outcome. **2. Identification of others with potential to be affected:** All residents residing in the facility have the potential to be affected. Nurse managers completed review of residents medical record to ensure abnormal laboratory results have been addressed by physicians. No other residents were affected by this deficient practice.	12/11/20

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F 773	Continued From page 41 elevated at 15.15. Please consider increasing the Levoxyl dose to 175 mcg daily at 0600 (6:00 AM) for [Hypothyroidism] and a follow-up TSH in 6-8 weeks." In addition, subsequent review showed Consultant #1 (pharmacist) documented on the "Pharmacy Drug Regimen Review" on dates 6/9/2020, 7/11/2020, 8/7/2020, and 9/8/2020, "No clinically significant medication issues were identified during the drug regimen review." During a telephone interview conducted on 10/6/2020, at 12:12 PM, Consultant #1 stated, "Resident's TSH levels have been hard to regulate. I asked for follow-up labs 6-8 weeks in February." During a telephone interview conducted on 10/6/2020, at 1:19 PM, Employee #16 (medical doctor), stated, "We should have repeated another TSH level. The patient has been difficult to regulate due to underlying disease. Will order follow-up lab." Facility staff failed to act on elevated TSH level since February 2020, for Resident #50. During telephone interviews conducted on 10/16/2020, both Consultant #1 and Employee #16 acknowledged the findings.	F 773	**3. Measures to prevent recurrence:** Medical director will provide education to physician and facility pharmacy consultant on the importance of consistent review of residents' medical record and follow up with abnormal laboratory result. Training will address consistent monthly pharmacy review of residents' clinical record with emphasis on ensuring that previous recommendations are being followed up. Assistant Director of Nursing / Designee will conduct audit during daily clinical round to ensure that abnormal laboratory results have been reviewed and addressed by physician and that pharmacy consultant recommendations are being followed up. Findings will be reported to Director of Nursing. **4. Monitoring corrective action:** Director of Nursing/Designee will report findings weekly x 4 during risk management meeting and submit monthly x 3 to Quality Assurance Committee.	12/11/20
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		

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F 804	Continued From page 42 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations and interview, facility staff failed to distribute and serve foods under sanitary conditions as evidenced by breakfast food items such as scrambled eggs and ground turkey that were tested below 135 degrees Fahrenheit (F), and inconsistent food temperatures documentation during the months of July, August, and September 2020. Findings included ... 1. Facility failed to maintain breakfast food temperatures that were safe and appetizing to Resident #51. During a face-to-face interview with Resident # 51 on 10/01/20, at 11:32 AM, he stated, "My food in the morning is cold." On October 7, 2020, at 8:57 AM a test tray containing breakfast foods was measured to determine the food temperatures. The food temperatures were as follows: Ground turkey from the regular diet test tray tested at 119.2 degrees F, and scrambled eggs tested at 123.3 degrees F. Breakfast food temperatures were inadequate and failed to test above 135 degrees Fahrenheit (F).	F 804	**1. Corrective action for the Resident affected.** Resident #51 is stable and resides in the facility. Resident #51 has been encouraged to report food temperature issue for immediate follow up. Resident #51 did not suffer any negative outcome. **2. Identification of others with potential to be affected:** All residents residing in the facility have the potential to be affected. Interdisciplinary team members completed residents' interview on all units to identify complain of disatisfaction with meal temperature and presentation. No other residents were identified As being affected.	12/11/20

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F 804	Continued From page 43 During a face-to-face interview on October 9, 2020, at approximately 10:30 AM, Employee #11 acknowledged these findings. 2. Dietary staff failed to document tray line food temperatures consistently during the months of July, August, and September 2020. Breakfast, lunch, and/or dinner tray line food temperatures were not documented as follows: Four (4) out of 31 days in July 2020 Eight (8) out of 31 days in August 2020 Fifteen out of 30 days in September 2020. During a face-to-face interview on October 9, 2020, at approximately 10:30 AM, Employee #11 acknowledged these findings.	F 804	**3. Measures to prevent recurrence:** Director of Food Services will provide in-service for dietary staff on the importance of providing meals at temperatures that are safe and apetizing at minimum of 135 degrees (F) on delivery. Training will emphasize on the importance of consistent documentation of tray line food temperature for all meals. Dietary Supervisor will conduct test trays two days every week to ensure appropriate food temperatures when delivered to the unit. Meal temperature log will be audited daily by Dietary Supervisor to ensure consistent and accurate meal temperature documentation. Identified issues will be reported to the Director of Food Services.	12/11/20
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842	**4. Monitoring corrective action:** Director of Food Services / Designee will submit report including issues identified and addressed to Quality Assurance Committee monthly x 3.	

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F 842	Continued From page 44 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842	**1. Corrective action for the resident Affected:** Residents #61 and #158 are stable and have been re-assessed; AV graft/fistula sites are intact and positive for bruit and thrills. Resident #83 is stable and has been re-assessed for splint usage, fall precautions, perineal care, skin impairment, vital signs for Covid 19 and turning and repositioning to ensure resident #83 has no negative outcome. Residents #61, #158, and #83 did not Suffer any negative outcome. **2. Identification of others with potential To be affected:** All residents residing in the facility have potential to be affected. Nurse managers completed medical record audit including Treatment Administration Record (TAR) and residents' receiving hemodialysis to ensure consistent documentation of AV graft/fistula dressing removal post dialysis. No other residents were identified as being affected .	12/11/20

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F 842	Continued From page 45 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview of three (3) of 43 sampled residents, the facility staff failed to consistently document the removal of the protective dressing covering the residents access site post dialysis for two (2) resident's receiving dialysis, to consistently document one (1) resident's treatment on the Treatment Administration Record [TAR]. Residents' #61, #83, and #158. Findings included... 1. Facility staff failed to consistently document the removal of Resident #61's protective dressing post dialysis. According to Fistulafirst, Renal Disease Council, Inc. ESRD (End stage Renal Disease) Network 18 Tool Kit..."After bleeding has stopped, dress the site with new gauze and tape or with a Band-Aid. Repeat Steps 3-10 for the second needle. Instruct the patient to remove the dressing 3-4 hours following treatment. Notify the charge nurse if the patient has prolonged bleeding or other abnormal symptoms." www.esrdnetwork18.org > pdfs > QI - FF Tools >	F 842	**3. Measures to prevent recurrence:** Staff Development Director will provide education to licensed nursing staff on consistent documentation in residents' Treatment Administration Record (T.A.R.), and AV graft/fistula dressing removal post dialysis. Director of Nursing/Designee will audit residents' medical record during daily clinical round to ensure Treatment Administration Record are being completed to reflect care provided, and documentation completed on AV graft/Fistula dressing removal post dialysis. **4. Monitoring corrective action:** Findings from the audit will be presented Weekly x 4 during risk management Meeting and forwarded to Quality Assurance Committee monthly x 3.	12/11/20

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	095036	A. BUILDING ______ B. WING ______	10/13/2020

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F 842	Continued From page 46 FF ToolKit Resident #61 was admitted to the facility on July 22, 2016, with diagnoses to include End-stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, and Anemia A review of the Progress notes dated September 1, 2020, through October 9, 2020, [17 dialysis days] showed the protective dressing to the resident's access site was documented as removed for six (6) days out of the 17 dialysis days reviewed. The evidence showed that facility staff were not consistent in documenting that Resident #61's protective dressing to his/her access site was removed post dialysis for 11 of 17 days. During a face-to-face interview conducted on October 9, 2020, at approximately 1:15 PM with Employee #2. She acknowledged the findings. 2. Facility staff failed to consistently document the treatments Resident #83's received on the Treatment administration record (TAR). Resident #83 was admitted to the facility on April 18, 2018, with diagnoses to include Diabetes Mellitus 2, Hypertension, Hyperlipidemia, hypothyroidism, impulse disorder, Alzheimer's disease, Peripheral vascular disease, and Osteoarthritis. A review of the Treatment Administration Record for August 2020, showed that on Sunday August 9, 2020, the space allotted to sign for Resident's	F 842		

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F 842	Continued From page 47	F 842		

#83 "splint removal, fall precautions, Perineal care, skin impairment, Turn and reposition, vital sign for Covid 19" were left blank, indicating that the documentation was incomplete.

During a face-to-face interview conducted on October 9, 2020, at approximately 1:15 PM with Employee # 2. She acknowledged the findings.

3. Facility staff failed to document the removal of Resident #158's protective dressing post dialysis.

According to Fistulafirst, Renal Disease Council, Inc. ESRD (End stage Renal Disease) Network 18 Tool Kit..."After bleeding has stopped, dress the site with new gauze and tape or with a Band-Aid. Repeat Steps 3-10 for the second needle. Instruct the patient to remove the dressing 3-4 hours following treatment. Notify the charge nurse if the patient has prolonged bleeding or other abnormal symptoms."
www.esrdnetwork18.org > pdfs > QI - FF Tools > FF ToolKit

Resident #158 was admitted to the facility on November 21, 2014, with diagnoses to include Anemia, Hypertension End stage Renal Disease, Dependence on Renal Dialysis, and Diabetes Mellitus.

A review of the Progress note dated September 1, 2020 through October 9, 2020 [16 days] showed the dressings to the resident's left AV [Arteriovenous] graft access site was intact on 2 dialysis days.

However, there was no documented record in the

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F 842	Continued From page 48 progress note to show that the protective dressing covering Resident # 158's access site was removed post dialysis on any of the 16 days reviewed. A face-to-face interview conducted with Employee #2 on October 9, 2020, at approximately 1:15 PM. She acknowledged the findings.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880	**1. Corrective action for the resident Affected:** Employee #17 acknowledged being educated on the facility's policy for PPE wear. Employee #17 was re-educated by the Infection Control and Preventionist Officer on facility's policy for "Screening & use of Personal Protective Equipment" with focus on item #12 on the policy that stated, "All employees are required to wear face mask at all times when in the facility. Universal eye protection is required when providing direct patient care or in-patient care areas." Employee was provided with re-clarification on the interpretation of patient care areas. Employee #17 verbalized and demonstrated understanding.	12/11/20

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F 880	Continued From page 49 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, in one	F 880	**2. Identification of others with potential To be affected:** Residents in the facility have potential to be affected. Rehabilitation Director reviewed facility policy on the use of Personal Protective Equipment with all therapists to ensure full intent and clear understanding of the policy with emphasis on the meaning and definition of "patient care area" to include every area in the facility and rehabilitation hall. No other resident was affected by the deficient practice. **3. Measures to prevent recurrence:** Staff Development Director will provide pre and post-test on the use of personal protective equipment to all therapists for evaluation of accurate understanding of the facility screening and use of personal protective equipment policy. Rehab Director will conduct daily round to ensure compliance and report findings weekly x 4 and then monthly x 3 to the Director of Nursing.	12/11/20

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F 880	Continued From page 50 (1) of one (1) observation, facility staff failed to wear required personal protective equipment (PPE) while in a resident care area to help minimize the transmission of COVID-19 to residents and other staff in the facility. Findings included... Facility staff failed to wear required personal protective equipment while in a resident care area. During a tour of the third-floor rehabilitation unit on 10/5/2020, at 1:52 PM, Employee #17 (physical therapy assistant, PTA) was observed without a face shield and with facemask pulled down below her chin. A review of the policy entitled, "Screening & Use of Personal Protective Equipment (PPE) During An Epidemic" dated 9/1/2020, item #12 showed, "All employees are required to wear face mask at all times when in the facility. Universal eye protection is required when providing direct patient care or in-patient care areas such as all facility nursing units." During a face-to-face interview conducted on 10/5/2020, at 1:52 PM, Employee #17 (PTA) stated, " I took the face shield off because I was just sitting here documenting." Employee #17 acknowledged being educated on facility's policy for PPE wear. Facility staff failed to maintain infection control	F 880	**4. Monitoring corrective action:** Director of nursing/Designee will present findings during weekly risk management meeting for review. Report will be forwarded to Quality Assurance Committee monthly x 3.	12/11/20

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F 880	Continued From page 51 practices and protocols by not wearing required personal protective equipment while in a resident area to help minimize the transmission of COVID-19 to residents and other staff in the facility.	F 880		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, facility staff failed to maintain essential equipment in safe condition as evidenced by a loose door that failed to close as intended, a broken temperature gauge and a broken temperature adjustment knob from one (1) of two (2) food warmers, and two (2) of six (6) slats from one (1) of one (1) walk-in freezer that were torn. Findings included ... 1. The access door to one (1) of two (2) food warmers was loose and failed to close as intended. 2. The temperature gauge and the temperature adjustment knob from one (1) of two (2) food warmers were broken. 3. Two (2) of six (6) slats in the walk-in freezer were torn.	F 908	**1. Corrective action for the resident Affected:** Loose and failed food warmer access door was repaired to function as intended. Identified food warmer broken temperature gauge and temperature adjustment knob have been replaced and food warmer is functioning as intended. Torn slats of the walk-in freezer were removed and replaced with new set. Residents did not suffer any negative Outcome.	12/11/20

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F 908	Continued From page 52 During a face-to-face interview on October 9, 2020, at approximately 10:30 AM, Employee #11 acknowledged these findings.	F 908	**2. Identification of others with potential To be affected:** Residents in the facility have the potential to Be affected. Assistant Maintenance Director/Designee conducted an inspection on essential kitchen equipment to identify broken, torn, loose, or equipment not functioning as intended to ensure repair, or replacement. No other equipment were identified. **3. Measures to prevent recurrence:** Facility's Maintenance Director/Designee will in-service maintenance and kitchen staff on importance of routine inspection of essential kitchen equipment to foster timely detection, repair, or replacement of defective equipment. Maintenance Assistant Director/Designee will conduct daily equipment check to ensure safe operating conditions of kitchen equipment. Findings will be reviewed with Director of Food Services and Maintenance Director weekly x 4 and monthly x 3. **4. Monitoring corrective action:** Report and findings will be presented weekly by Director of Food Services during risk management meeting and forwarded to Quality Assurance Committee monthly x 3.	12/11/20