VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

June 14, 2024

Ms. Amanda Moxley, Administrator
Barre Gardens Nursing and Rehab, LLC
378 Prospect Street
Barre, VT 05641-5421

Dear Ms. Moxley:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **May 9, 2024.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

PamelaMCotaRN
Pamela M. Cota, RN
Licensing Chief

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475037	A. BUILDING _____ B. WING _____	C 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARRE GARDENS NURSING AND REHAB LLC	378 PROSPECT STREET BARRE, VT 05641

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E 000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 5/8/2024. There were no regulatory violations identified.	E 000	The filing of this plan of correction does not constitute an admission of the allegations set forth in the statement of deficiencies. Barre Gardens has prepared and executed a plan of correction as evidence of the facility's continued compliance with applicable law.	
F 000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey, complaint investigation, including reports #22504, #22609, #22701, and #22982, and facility reported incident investigations, including reports #22729 and #22675, from 5/6/2024 through 5/9/2024, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During the recertification survey, the survey team identified substandard quality of care as a result of a violation at 483.10(a)-(b)(1)&(2)- F550 and an onsite extended survey was conducted in conjunction with the recertification survey. The following deficiencies were identified:	F 000		
F 550 SS=F	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550	1) All residents in the facility are at risk for this alleged deficient practice. The facility has changed its locked door policy from being locked 24 hours per day, 7 days per week to being unlocked during normal business hours, Monday through Friday, 8am to 5pm. Visitors will ring the doorbell to enter the facility after normal business hours and on weekends.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda [illegible]	Administrator	Revised 6/13/24

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 550	Continued From page 1 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 observation and interview, the facility failed to ensure each resident has a right to self-determination and access to persons and services outside of the facility, by locking all doors to the facility 24 hours a day, 7 days a week. By creating a locked facility, there is a failure to ensure the right of each resident to exercise their rights as a citizen (or resident) of the United States or make personal choices about going outside without interference. This has the	F 550	The Facility will invest in a doorbell camera system. When a visitor rings the doorbell, staff on the units will permit entry remotely. All staff will be educated on resident's rights, the change in the facility's door policy, and after hours visitations. The audit results will be reviewed at QAPI for further interventions. 2) Resident #47 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents who are on the facility's "overnight get up list" are at risk for this alleged deficient practice. Interviews will be completed with all residents, who are currently on the " overnight get up list" to ensure resident's preference for "get up time". Unit manager, licensed nurses and licensed nursing assistants will be educated on the importance of resident's choice and the "overnight get up list".	

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F 550	Continued From page 2 potential to affect all residents of the facility and all visitors, including family, legal representatives and advocates. The facility also failed to ensure residents had the right to get up at the time they want for 1 of 24 sampled residents (Resident #47), failed to have resolution for missing clothing for 3 of 24 sampled residents (Residents #47, #18, and #15), failed to schedule Resident Council meetings at times determined by the residents, and failed to ensure that 2 of 7 residents being served and assisted with meals were treated with dignity and respect, by not providing meals and nutrition while all other residents in the room, including those sitting at the same table were served and eating their meal (Resident #62 & #43). Findings include: 1.) Per observation on 5/6/24 at approximately 10 AM for initial entrance to the building to start survey, the main front entrance building doors within the foyer were locked. A staff member approached the inside doors to the foyer, they entered a code on a code pad and opened the doors for the survey team to enter. Per observation on 5/7/24 at 9:05 AM, this surveyor was unable to enter the building independently. In order to enter the building, a doorbell had to be pressed to alert staff, and then a staff member arrived to open the door. At 12:30 PM when this surveyor needed to exit the building, it was not possible to do so independently. There is a sign posted on the inside of the doors that states: "*ATTENTION* These doors are always locked for the safety of our residents. Please see a staff member to Exit the building." This writer had to interrupt a staff person in the midst of their job duties to request to exit the building. The staff member accessed a panel to the left of the main	F 550	The DNS or designee will conduct random weekly audits X 4 and monthly audits X 2 to ensure residents on the "overnight get up list" are assisted with getting out of bed at preferred time. The audit results will be reviewed at QAPI for further interventions. 3) Residents #47, #18, #15 and #51 continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. The facility was unaware of resident #47's missing clothing and had no knowledge of the $200 incurred to replace missing clothing. The facility's social worker spoke with resident to retrieve the receipt so the facility could reimburse. It was at this time that the resident stated s/he did not notify any staff of the missing clothing or $200 cost to replace them. Grievance was started and the facility is awaiting the receipt for reimbursement.	

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F 550	Continued From page 3 exit doors to enter a code to open the door. This was the process for the entire survey, from 5/6/24 - 5/9/24. Observations from 5/6/24 - 5/9/24 revealed no residents sitting independently outside in either the courtyard, the fenced in area, or in the front of the building. Per interview on 5/6/24 at approximately 1:30 PM with Resident #47 and their spouse, they stated that they do not understand why they and their spouse could not enter or exit the facility without staff assistance. The spouse stated that when they come to visit, they have to ring the bell outside in the foyer and wait for assistance. They have asked staff for the code so they can come and go as they please, but they were told by the Administrator and several other staff that there are strict rules against giving the code to residents or family members/visitors, and they were not allowed to give it out to anyone but staff. S/he stated that "it seems the residents are prisoners here and once you come in to visit so are you, until a staff can let you out, it's just not right". Resident #47 stated that s/he was not allowed all last year to go outside and sit by themselves, a staff member had to open the door and go out and sit with them, and usually there was not enough staff to do that. Resident #47 was upset that their spouse couldn't come and go as they pleased and that there were many times they had to wait for someone to come and open the door, stating often times it was a long wait if there wasn't someone right nearby. Per interview on 5/7/24 at approximately 11:00 AM, regarding these concerns, the facility's Social Worker stated that it is corporate policy to keep the doors locked and residents and family/visitors are not allowed	F 550	On 12/18/2023, resident #18's family member delivered resident's sweater to social worker requesting replacement due to its condition after being washed and dried at the facility. Social worker offered to steam the sweater, and if that didn't work, agreed to have sweater replaced. Sweater returned to original state after being steamed. Social worker brought the sweater to resident, and s/he was satisfied with the outcome. Social worker reviewed this incident with the surveyor on 5/7/2024 to advise of resolution. Facility was unaware of residents #15 and #51's missing/damaged clothing until the surveyor brought it to social worker and administrator's attention. Grievances have been completed and resolved. On 5/14/2024, administrator attended resident council and educated residents on the grievance policy and procedure. All staff will be educated regarding the grievance and policy and procedure to ensure resident concerns are addressed. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure grievances are addressed.	

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F 550	Continued From page 4 to have the codes to the doors. Per interview on 5/06/24 at 4:01 PM, Resident #26's family member explained that s/he has to wait a long time to get into the facility to visit because the doors are locked. Per interview on 5/7/2024 at 3:45 PM, Resident #23's Representative explained that s/he has had to wait a very long time to get let into the facility multiple times and sometimes it takes 45 minutes to an hour before someone will let you in, which is very frustrating. A Resident Council meeting with the survey team occurred on 5/8/24 at approximately 9:30 AM, and there were five attendees, Residents #15, 18, 50, 51, and 54. Resident #54 stated that there is a concern about the facility doors always being locked and residents and visitors always having to ask to come and go. Residents #15, 18, 50, and 51 confirmed that this was an issue. Residents stated that they have asked why the doors are locked and why they can't go out when they want to and are told it is for resident safety. Residents stated that the last two days have been really nice days and no one was able to go outside and sit and enjoy the sunshine because there was no one that could stay out there with them. Residents confirmed that the facility "requires a staff member to stay with us and it doesn't matter if we have out wits about us or not". Resident #54 stated that they asked several times "yesterday", 5/7/24 to go outside and was told, "when we have someone that can go out with you, right now we don't have anyone available". Per interview on 5/9/24 at approximately 10:35 AM, two LNA's explained that the doors to the	F 550	4) All residents in the facility are at risk for this alleged deficient practice. Administrator spoke with activities director who confirmed that she set the dates for resident council meetings every month. She also confirmed that the resident council meetings are posted on the monthly activities calendar, giving residents ample notice to invite their families if they desire. Activities staff will be educated on the importance of residents' rights and their involvement of scheduling resident council meetings. Administrator or designee will conduct random audits monthly X 3 to ensure residents are scheduling resident council meetings. 5) All residents in the facility are at risk for this alleged deficient practice. Administrator or designee will observe meal service to ensure residents are being served in a timely manner and utensils are available. Unit managers, licensed nurses, licensed nursing aides, and dietary department will be educated on the importance of timely meal service and ensuring residents have utensils available to them at the time that their meal is provided.	

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F 550	Continued From page 5 facility are always locked and the staff have been told to never give the door codes to the residents or visitors. Surveyor asked what the reasoning is behind this, and LNA #1 stated that s/he believes it is due to the number of dementia residents in the facility and "we don't want them to escape". Surveyor asked if the doors are ever unlocked and LNA #1 stated "no, never - not since I've worked here." (for about a year and a half). Interview on 5/9/24 at approximately 10:48 AM, the Activities Director stated that the doors are always locked. Surveyor asked if residents or family members/visitors had the code so they could come an go as they please, to which they responded, "No, that is absolutely forbidden, only staff are allowed to have the codes." Per interview on 5/7/24 at 1:10 PM, the Administrator stated that the doors have been locked since they began working here in October 2022. The Administrator stated that their boss "PHG" [Priority Health Group, which is the ownership entity] wants the doors locked. Per the Administrator, the facility has alert and independent residents in their population. The Administrator was not able to locate a policy or procedure for the doors being locked or for operating a locked facility, and stated that the "official rule" is to not give the codes to any resident or visitor. When asked if there is a process for assessing residents and ensuring those without safety risks can exit the building independently, it was repeated that no resident is allowed to have the code. The Administrator confirmed that no resident can exit the building at any time without staff assistance. The only material in writing that was located upon request regarding operating a locked facility was in	F 550	Administrator or designee will conduct random weekly audits X 4 and monthly X 2 to evaluate timely meal service and ensure residents have utensils available. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 550 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 550	Continued From page 6	F 550		

orientation paperwork, where it is noted that new staff are trained on "Emergency Door Alarms (Codes)", with no further training materials, direction or procedures.

2.) Per interview on 5/6/24 at approximately 1:30 PM with Resident #47 and their spouse, Resident #47's spouse stated that s/he is also upset that Resident #47 is having to get up at 5 AM every morning or they have to wait until 10 AM to get up when staff have time. The surveyor asked why Resident #47 has to get up at 5 AM. Resident #47 stated that the LNA's wake him/her up at 5 AM and tell them that if s/he doesn't want to get up then they will have to wait until 10 AM or when staff have time. Per interview on 5/9/24 at approximately 10:35 AM, Surveyor asked LNA #1 and LNA #2 about the resident and family's complaints regarding staff getting Resident #47 up at 5 AM or having to wait until 10 AM. Both LNA #1 and LNA #2 confirmed that this resident is on the list to be gotten up by the night shift. The LNA's stated that he could be moved to a later time during night shift.
Interview on 5/9/24 at approximately 2:15 PM The Administrator was not aware that Resident #47 was being told they need to get up at 5 AM or wait until around 10 AM, but that the resident may be on a list of early risers so this could be why the staff get him/her up so early.

3.) Per interview on 5/6/24 at approximately 1:30 PM with Resident #47 and their spouse, Resident #47's spouse stated that Resident #47's clothes have gone missing and they have recently had to spend $200 to replace all the missing clothes. They stated that they have brought all these issues up to the social worker to no avail, stating "nothing has been done to resolve any of these

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F 550	Continued From page 7 issues". Per interview on 5/7/24 at approximately 11:00 AM with the facility's Social Worker, the Social Worker stated that she was not aware that Resident #47 was missing any clothes, or that their spouse had recently spent $200 to replace missing clothes. Resident Council meeting occurred on 5/8/24 at approximately 9:30 AM, there were five attendees, Resident #'s 15, 18, 50, 51, and 54. Residents stated they had missing clothes that the facility has not addressed. Resident #18 stated they had a sweater that was damaged and was told the facility would reimburse them for it, stating "that was 6 months ago and still nothing". Resident #15 is missing a sweater that never came back from the laundry. S/he stated that staff were aware as they had stated they had tried to locate it in the laundry but could not, but said "they are keeping their eye out for it". Resident #51 stated that they had a pair of pants that came back from the laundry damaged, staff are aware but nothing has been done about it. The Resident Council Co-President stated s/he was aware of all the missing clothes, staff are aware but there has been no resolution to this ongoing issue. Per interview on 5/9/24 at approximately 2:15 PM, the Administrator was aware of missing clothes but believed all issues had been resolved. 4.) Resident Council meeting occurred on 5/8/24 at approximately 9:30 AM, there were five attendees, Resident #'s 15, 18, 50, 51, and 54. Resident #54 stated that they and the other Co-President do not set the Resident Council	F 550		

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meeting, this is done by facility staff and no resident, not even the Co-Presidents find out about the date and time of the Resident Council meeting until the Chronicle (the facility paper) is circulated to residents. S/he feels that the Co-Presidents should be setting up each Resident Council meeting and notifying the facility of the date and time. S/he stated that the Resident Council would like to invite family members but they are not provided enough time to notify families of these meetings. Resident #15, 18, 50, and 51 confirmed that the facility does not give residents enough notice to be able to invite their families.

Per interview on 5/9/24 at approximately 2:15 PM, the Administrator stated that the Resident Council meeting is set up by the Activities Director, once the date has been set it is posted in the Chronicle and distributed to the residents and they can notify family if they want them to attend. S/he was not aware what the time frame looked like regarding the Chronicle distribution and the date and time of the Resident Council meeting.

5.) Per observation on 5/06/24 at 5:10 PM there were six residents sitting in the sunroom waiting for their dinner meal. At 5:12 PM a cart with meal trays was delivered to the sunroom and the licensed nursing assistant (LNA) began passing trays to the residents.

At 5:20 PM Resident #43 was served their meal with three bowls of food and two drinks. S/he drank from cups but was unable to eat the meal because there were no utensils available at her/his seating. At 5:26 PM a licensed nursing assistant (LNA) sat down and attempted to assist Resident #43 who was viably upset with the LNA

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F 550	Continued From page 9 and refused assistance. At 5:43 PM, thirty one minutes after the start of meal service, Resident #62 still had not been served their meal. The unit manager entered the sunroom an began to assist with the meal. At 5:49 PM Resident #62 received a tray with SpaghettiOs and pudding. During an interview on 5/6/2024 at 5:50 PM the unit manager (UM) was asked about the process of tray delivery and service. The UM stated that tray tickets are in the main dining room and when a resident is not there, dietary staff make a tray to be passed on the unit. The UM stated that Resident #62 typically prefers SpaghettiOs and usually eats in the main dining room. The UM confirmed that Resident #62 had not received their tray in a timely manner and was provided SpaghettiOs after all other residents were finished with their meal.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide reasonable accommodation of resident needs for 1 of 24 residents in a standard survey sample (Resident #53). Findings include:	F 558	Resident #53 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. When brought to staff's attention that resident #53 couldn't reach their call light, staff corrected the issue immediately. A longer cord was provided and put in resident's reach. A house wide audit will be conducted to ensure call lights were within residents' reach.	

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F 558	Continued From page 10 Interview on 5/6/24 at approximately 2:35 PM, Resident #53, who was laying in their bed was asked about call bell access and staff response time. S/he stated, "That's laughable, staff never make sure I have my call bell. Do you see it anywhere?" Observation on 5/6/24 at approximately 2:37 PM revealed Resident #53 with no access to the call bell system. Upon the residents bedside table was a white coiled call bell cord which was not within Resident #53's reach. At the same time as this observation, the LPN assigned to resident #53 had been assisting Resident #53's roommate and had heard the conversation between Resident #53 and the surveyor. The LPN located the residents call bell on their bedside table and attempted to provide it to the resident. S/he stated, "I have clipped it [call bell] to your pillow case." The surveyor asked the resident if they could reach the call bell now that it was clipped to their pillow case, the resident stated, "No, I can't see it or find it when I feel for it. Why can't it be attached to my bed rail so I can actually find it and use it when I need it?" Interview on 5/6/24 at approximately 2:40 PM with the LPN who stated they were not aware that the resident has not been able to access their call bell. They stated that the cord is not long enough to reach the resident well, but they were not aware that the resident had not had access to their call bell. The nurse stated that they would speak with maintenance and see if a longer cord could be located. Record review revealed Resident #53 is care planned for potential for falls due to a decline in their functional status, hemiplegia/hemiparesis	F 558	All staff will be educated on ensuring call lights remain within residents' reach. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 to ensure call lights remain within residents' reach. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 558 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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	475037	A. BUILDING _____ B. WING _____	C 05/09/2024

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F 558	Continued From page 11 and muscle weakness and an intervention listed states, "Keep call bell within reach/encourage use/answer promptly".	F 558		
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; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (c)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584	1) Residents #47 and #50 continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure no other rooms had missing chair rail strips from walls. Maintenance will be educated on residents' rights to a safe, clean, comfortable and homelike environment, and the importance of fixing environmental issues. Maintenance will advise administrator of maintenance delays. Rooms missing chair rail strips will have existing built-up glue removed so that the new adhesive may be applied to ensure secure fit. The administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all missing chair rail strips are replaced and remain intact. The audit results will be reviewed at QAPI for further interventions.	

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F 584	Continued From page 12 §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 upon observation, interview, and record review, the facility failed to ensure a safe, clean, comfortable, and homelike environment was maintained for the residents on 1 of 2 units (Unit 1). Findings include: 1. Observation on 5/6/24 at approximately 12:57 PM of Resident #47 and #50's room revealed a strip approximately 4-6 inches wide at chair rail level, that runs the full length of the right hand side of the residents room. The strip was falling off the wall and was laying on the foot of Resident #47's bed. Interview on 5/6/24 at approximately 1 PM with Resident #50, they confirmed that this chair rail strip keeps falling off and the maintenance man keeps re-gluing it and placing it back on the wall. Interview on 5/6/24 at approximately 1:15 PM with Resident #47, they confirmed that this chair rail strip keeps falling off and the maintenance man keeps re-gluing it and putting it back on the wall. Resident #47 stated that their spouse has complained to staff about this many times and this strip just keeps getting put back up on the wall. The resident said, "if the maintenance guy would just strip off the old glue before re-gluing the strip to the wall and then placing a block between the wall and bed wheels, this wouldn't	F 584	2) Resident #53 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure call lights were within residents' reach. All staff will be educated on residents' rights to a safe, clean, comfortable and homelike environment, and the importance of ensuring call lights remain within residents' reach. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 to ensure call lights remain within residents' reach. The audit results will be reviewed at QAPI for further interventions.	

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F 584	Continued From page 13 keep happening". Interview on 5/6/24 at approximately 1:30 PM with Resident #47's spouse, they stated they have spoken to staff many times about this needing to be fixed and no one addresses it. Per interview on 5/7/24 at approximately 2:45 PM, the maintenance stated s/he is aware of this strip that keeps falling down and stated that s/he has reapplied this strip many times and now will need to take it down, scrape the wall of the glue and reapply it. S/he stated that this happens because when the staff raise and lower the beds the beds catch on the strip and pulls it off. 2. Per interview on 5/6/24 at approximately 2:35 PM, Resident #53, who was laying in their bed was asked about call bell access and staff response time. S/he stated, "That's laughable, staff never make sure I have my call bell. Do you see it anywhere?" Observation on 5/6/24 at approximately 2:37 PM revealed resident #53 with no access to the call bell system. Upon the residents bedside table was a white coiled call bell cord which was not within Resident #53's reach. At the same time as this observation, the LPN (Licensed Practical Nurse)assigned to resident #53 had been assisting Resident #53's roommate and had heard the conversation between Resident #53 and the surveyor. The LPN located the residents call bell on their bedside table and attempted to provide it to the resident. S/he stated, "I have clipped it [call bell] to your pillow case." The surveyor asked the resident if they could reach the call bell now that it was clipped to their pillow case, the resident stated, "No, I can't see it or find it when I feel for it. Why can't it be attached to my	F 584	3) All residents in the facility are at risk for this alleged deficient practice. Administrator notified the regional maintenance director about the dips in the floor immediately. S/he told the administrator that the dips are caused from the drains not being properly leveled out when the flooring company laid the new floors down. S/he is working on a plan of action to ensure the dips are removed. Maintenance director to call local vendors for quotes to fix both areas of concern. The progress of this large project will be reviewed at QAPI for further interventions if needed. 4) All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to see how many residents have privacy curtains bundled.	

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F 584	Continued From page 14 bed rail so I can actually find it and use it when I need it?" Interview on 5/6/24 at approximately 2:40 PM with the LPN who stated they were not aware that the resident has not been able to access their call bell. They stated that the cord is not long enough to reach the residents well, but they were not aware that the resident had not had access to their call bell. The nurse stated that they would speak with maintenance and see if a longer cord could be located. Record review revealed Resident #53 is care planned for potential for falls due to a decline in their functional status, hemiplegia/hemiparesis and muscle weakness and an intervention listed states, "Keep call bell within reach/encourage use/answer promptly". 3. Per observation on 5/7/24 at approximately 11:00 AM on Wing 1 short hall, there is a deep indentation in the linoleum of the left side of the hallway floor directly in the line of ambulation. A second indentation in the linoleum on the left side of the hallway in the line of ambulation was noted on Wing 2 short hall. Per interview on 5/7/24 at approximately 2:45 PM, the maintenance was asked about the two indentations in the linoleum on both wings. S/he explained that these areas are where drains are in the floor and stated these are no longer utilized, so when the linoleum was put down they just went over the drains. S/he stated that they would need to figure out how they might be able to fix the floors so the indentations don't reappear.	F 584	Due to space restrictions in resident rooms and the way in which some residents' furniture is arranged, privacy curtains sometimes hang in inconvenient locations. In an attempt to remedy this, the facility bundles the privacy curtain up to ensure it is out of the residents' way. The facility will look into whether residents who have bundled privacy curtains can have their beds relocated so the curtain doesn't hang in an inconvenient spot. Some residents have their beds care planned to be in a specific spot. In instances such as these, the facility will relocate the curtain, so it is not an inconvenience to the resident. Surveyor concurred. Unit manager, licensed nurses, and licensed nursing assistant will be educated on the importance of ensuring privacy curtains are hung in an area convenient for the resident and does not disrupt their daily routine. The administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure privacy curtains are hung in an area that is convenient for the resident and does not disrupt their daily routine.	

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F 584	Continued From page 15 4. Observation on 5/9/24 at approximately 1:35 PM in Resident #47 and #50's room revealed the left side of the residents area over the resident bed was a privacy curtain that was tied up at the foot section. The surveyor asked the resident about this and they stated that they "wished they would take it down or do something with it". Per observation and interview on 5/9/2024 at 11:20 AM, Resident #40 had a room partition curtain tied in a knot that hung over the center of his/her bed, just a few feet above the bed. Resident #40 explained that it bothers him/her to have that hanging there and s/he has told staff before that s/he doesn't like it. Per observation and interview on 5/9/2024 at 11:28 AM, Resident #246 had a room partition curtain tied in a knot that hung over the center of his/her bed, just a few feet above the bed. Resident #246 said that s/he did not like it there. Interview on 5/9/24 at approximately 2:15 PM with the facility administrator regarding the chair rail strip in Residents #47 and #50's room, the indentations in the linoleum on both units, and the privacy curtain that is tied up in over the foot of resident #47's bed. They stated that they are aware of all of these issues and that maintenance is taking care of the chair rail strip and the indentations in the floor. S/he stated that the curtains could not be taken down due to resident rights specific to privacy issues but that perhaps something else could be done to remedy the issue.	F 584	The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 584 POC accepted on 6/14/24 by S. Stem/P. Cota**	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656	Resident #23 continues to reside at the facility and had no ill effects from this alleged deficient practice.	

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F 656	Continued From page 16 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the 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	F 656	All residents who are on anticoagulants are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure care plans were updated for all residents on anticoagulants. All licensed nurses will be educated on updating care plans for resident who receives anticoagulants. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 on residents who are on anticoagulants to ensure their care plans have been updated. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 656 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 656	Continued From page 17 requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive care plan that addressed anticoagulant use for 1 of 4 sampled residents reviewed for anticoagulant use (Resident #23). Findings include: Per record review Resident #23 was admitted on 10/23/23 for rehabilitation following a hospital stay related to a urinary tract infection and sepsis. S/He has diagnoses that include heart failure, chronic pulmonary embolism (a blood clot that forms a blockage in the artery of the lung), and pacemaker. A 10/30/23 admission Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) reveals that Resident #23 was admitted taking an anticoagulant. Admission orders reveal a physician order for "enoxaparin [Lovenox; an anticoagulant, used to prevent and treat blood clots] 120 mg/0.8 mL injection, inject 120 mg into the skin for 90 days." Review of Resident #23's care plan reveals that Resident #23 did not a have a care plan that addressed the use of anticoagulants until 4/18/24. Per interview on 5/09/24 at 9:50 AM, the Unit Manager confirmed that any resident on an anticoagulant should have an anticoagulant care plan. Per interview on 5/08/24 at approximately 3:50	F 656		

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F 656	Continued From page 18 PM, the Director of Nursing confirmed that all residents that are on anticoagulant should have an anticoagulant care plan and Resident #23 did not until 4/18/24.	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 by: Based on staff interview and record review, the facility failed to revise the comprehensive care	F 657	1) Resident #23 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents who have catheters and receive pain management are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure care plans were updated for all residents who utilize catheters and receive pain management. All licensed nurses will be educated on ensuring care plans are updated for all residents who utilize catheters and receive pain management. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 on residents who utilize catheters and receive pain management to ensure their care plans are up to date. The audit results will be reviewed at QAPI for further interventions.	

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F 657	Continued From page 19 plan as the resident's plan of care changes for 2 of 27 sampled residents (Resident #23 and #62) related to catheter use and pain management for Resident #23 and activity preference for Resident #62. Findings include: 1. Per record review Resident #23 was admitted on 10/23/23 for rehabilitation following a hospital stay related to a urinary tract infection and sepsis. S/He has diagnoses that include uropathy (blockage in the urinary tract), bladder cancer, heart failure, chronic pulmonary embolism (a blood clot that forms a blockage in the artery of the lung), rheumatoid arthritis, peripheral neuropathy (nerve damage), and lung cancer. A 10/30/23 admission Minimum Data Set (MDS; a comprehensive assessment used as a care-planning tool) reveals that Resident #23 was admitted without a catheter and has moderate pain for which s/he has received as need pain medication and is not on a scheduled pain medication regime. 1.a. Record review reveals that Resident #23 had been transferred to the hospital on 11/7/23 and returned to the facility on 11/13/24 with a catheter. Per review of Resident #23's care plan, s/he does not have a care plan focus or any interventions related to his/her use of a catheter until 1/23/24. Per interview on 5/09/24 at 9:50 AM, the Unit Manager confirmed that any resident with a catheter should have a catheter care plan in place. 1.b. Per interview on 5/07/24 at 9:26 AM, Resident #23's Representative explained that s/he had talked to facility staff, including the Nurse Practitioner (NP), multiple times about	F 657	2) Resident #62 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure all resident's activities care plans reflect activity preferences. Activities staff will be educated on resident center care, and care plan policy and procedure. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 of activity care plans to ensure residents are care planned for activities they prefer. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 657 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 657	Continued From page 20	F 657		

Resident #23 getting a leg bag so Resident #23 could be more independent. The Representative stated that s/he has never seen Resident #23 with a leg bag and s/he had first talked about it months ago with the NP.

Per observation and interview on 5/6/2023 at 10:03 AM, Resident #23 is sitting in his/her wheelchair. Catheter tubing is coming out from the bottom of his/her pants attached to a catheter drainage bag that is hanging on the bottom backside of the wheelchair. Resident #23 explained that s/he wishes s/he could be more independent. S/He explained that s/he had been working with rehab doing exercises to get stronger and s/he feels like s/he has made improvement but wishes s/he was able to use his/her walker more but can't really do it because s/he has a "huge bag" attached to his/her wheelchair. On 5/7/24 at approximately 11:30 AM, Resident #23 appeared to want to get up from his/her wheelchair. S/He seemed frustrated and stated that s/he doesn't know why they haven't given him/her the leg bag yet because they already told him/her s/he could have it.

Record review reveals a "Physician's Standard Written Order" form located in Resident #23's medical record, the Nurse Practitioner had ordered 1 standard Catheter Kit, 1 bedside drainage bag, 2 leg bags, and 1 leg strap for Resident #23 on 1/3/24.

Review of Resident #23's care plan reveals the following focus "The resident has an ADL [activities of daily living] Self Care Performance Deficit [related to] Limited Mobility," initiated on 10/23/23, with the goal "the resident will improve current level of function by next review," revised

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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on 3/1/24, and interventions that include "AMBULATION: supervision with walker," initiated on 10/25/23. Resident #23's care plan for ADLs or catheters reveals that it had not been updated to reflect the provider order for a leg bag on 1/3/24 or Resident #23's desire to use a leg bag.

Per interview on 5/08/24 at 10:36 AM, the Therapy Director stated that s/he remembered the use of a leg bag being brought up with the team in the past but was unsure about what had become of it.
Per interview on 5/8/24 at 11:42 AM, a Licensed Nursing Assistant explained that they are aware that Resident #23 would like a leg bag but cannot do anything to make that happen unless his/her care plan reflects that change and confirmed that s/he has not used a leg bag at the facility.

1.c. During multiple observations and interviews with Resident #23 on 5/6/24 through 5/9/24, Resident #23 did not appear to show signs of pain and while s/he stated that s/he did have a sore muscle in his/her leg from not walking enough s/he was not in pain.

Per interview on 5/07/24 at 9:26 AM, Resident #23's Representative stated that s/he is concerned that Residents #23 is still taking routine morphine. S/He explained that Resident #23 did have significant pain and a significant decline in their health status starting in December in which s/he was prescribed morphine for. S/He said s/he could understand the frequency and dosage of the morphine then because Resident #23 had declined to the point where they were discussing end of life care but now that s/he has completely turned around, and does not exhibit pain, s/he is afraid that s/he is being

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unnecessarily medicated. S/he had to talked to facility staff, including the Nurse Practitioner, multiple times about decreasing or taking Resident #23 off of the morphine.

Review of Resident #23's care plan reveals the following focus "The resident has acute pain/chronic pain [related to] cancer, RA [rheumatoid arthritis], peripheral neuropathy,' initiated on 10/23/24, with the goal, "The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date," revised on 3/1/24. Interventions including administer analgesia as order and "Evaluate the effectiveness of pain interventions. Review the compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition."

A 1/5/24 Nurse Practitioner note states that Resident #23 expressed a desire not to be in pain and end-of-life was discussed. A 1/9/24 NP note stated that morphine was ordered for pain. Resident #23 has a physician order for "Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 0.1 ml by mouth every 4 hours for pain, [shortness of breath]. This dosing and frequency has been consistent for Resident #23 since it was first ordered on 1/9/24 and Resident #23's Medication Administration Record reveals that the morphine has been administered as ordered since 1/9/24.

Review of Resident #23's vitals, Resident #23 has not reported pain since 2/2/24. A 4/15/24 quarterly MDS reveals that Resident #23 reported in a pain assessment interview that s/he has no pain.

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F 657	Continued From page 23 Facility policy titled "Level Pain Assessment and Management," last revised in 2015, states "If pain symptoms have resolved or there is no longer an indication for pain medication, the multidisciplinary team and physician shall try to discontinue or taper analgesic medications to the extent possible." There are no staff evaluations of the effectiveness of pain interventions or a clinical rationale for the continued administration of the morphine a medication based upon an assessment of the resident's condition and therapeutic goals after Resident #23's last positive pain assessment on 2/2/24. A 2/2/24 Attending Provider note reveals that the Attending Provider was not aware that Resident #23 was on scheduled morphine. His/her note states that Resident #23 is "currently on as needed morphine which seems to provide adequate pain control." There are no Nurse Practitioner notes that show evidence that they have evaluated Resident #23's morphine order or their change in their indication of pain. In addition to Resident #23's Representative wanting to change Resident #23's plan of care for pain management related to medication, and Resident #23 not having an indication for pain medication, a pharmacist medication regimen review note for Resident #26 from May of 2024 recommends "currently receiving Morphine 6 times daily. Please evaluate continued need, consider trial taper to 4 times daily, if appropriate." The provider checked the box "disagree". There is no rationale that can be located in the medical record for Resident #26 explaining why the physician did not want to	F 657		

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change the Morphine order. See F 757 for more information.

Resident #23's pain care plan interventions were last revised 10/23/24. There are no care plan revisions that reflect Resident #23's Representative's goal to change Resident #23's morphine order, Resident #23's lack of pain, or the pharmacy's recommendation to tapor Resident #23's morphine order.
2. Per record review Resident #62's activity care plan revised on 4/13/2024 states "The resident has little or no activity involvement r/t Anxiety, Depression, Sensory Deprivation unable to leave room, Rarely leaves room, unable to make needs known. Disordered thinking/awareness."

Per observations throughout survey Resident #62 was seen sitting in the sunroom conversing with staff, at the nurses station, walking the hall, and sitting in wheelchair in the hall. On 5/6/2024 s/he was observed in the sunroom with no activity from 9:45 until 12:30 PM when lunch was served. At 4:20 PM s/he was sitting in a wheelchair in the hall watching staff and residents walk up and down the hall.

Per interview with a Licensed Nursing Assistant (LNA) Resident #62 used to prefer to stay in her/his room before s/he had a fall in March which resulted in a fracture. Since then s/he is more social and "feisty now, and you can even understand [her/him] more." S/he onjoys sitting out in the common areas now and even jokes with the staff.

Per interview on 5/7/2024 at 4:30 PM the Activities Director said that Resident #62 doesn't really participate in activities but s/he does like to

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F 657	Continued From page 25 sit and watch. The Activities Director confirmed that Resident #62's care plan had not been updated to reflect that s/he does not stay in her/his room anymore and does attend some activities.	F 657		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an ongoing activities program to support residents in their choice of group, individual, and independent activities to meet the interests of and support the well-being of each resident as evidenced by a lack of engaging activities both in and out of resident rooms for 4 of 24 sampled residents (Residents #82, #3, #73, and #23). Findings include: 1. During an interview on 5/6/2024 at 1:30 PM Resident #82 stated that s/he wished that there were more activities for the residents. S/he is able to socialize and participate in independent activities but many cannot. S/he said that the some days there is not much going on and it is	F 679	Residents #82, #73, #23, and #3 continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. On May 7th, 2024, the facility hired an activity assistant. The activities department now has 1-2 activities personnel present in the facility 7 days per week to ensure residents are receiving daily activities. A house wide audit will be conducted to ensure all resident's activities care plans reflect their activity preferences. Activities staff will be educated on resident center care and care plan policy and procedure. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 of activity care plans to ensure residents are care planned for activities they prefer. Date of completion: June 20, 2024	

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F 679	Continued From page 26 starting to get to some of the residents. Per observation on 5/6/2024 at 11:10 AM there were 8 residents sitting in the sunroom with the television on. The Medical Records Specialist was in the room talking with the residents. Resident #3 was asking what crafts were happening and if there was going to be someone there who knew what they were doing with the crafts. The Medical Records Specialist offered Resident #3 some paper and colored pencils. Resident #3 stated that s/he did not want them, s/he wanted to do a craft. The medical records specialist was asked what type of activities are provided for the residents in the sunroom and s/he stated that it was an independent activities day which meant that there was no activity staff and an activity cart with things that residents could do on their own were provided. At 11:20 AM the Medical Records Specialist left the room. A white board hanging up across the nurses station read: "Sunday May 5th 2014 Monday May 6 2024 are independent activity days Activity carts are kept at each Nurses station with activity sheets provided. Games are provided in the dining area as well See you on Tuesday" Review of the April and May activities calendar provided by the activities director there were several days each week that state "Independent Activities Activity carts are at nurses station" The calendar reveals the following: 4/14 - 4/20 there were no formal activities offered on 4/14, 4/17, and 4/19 4/21 - 4/27 there were no formal activities offered	F 679	The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 679 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 679	Continued From page 27 on 4/21, 4/24, and 4/25 4/28 - 5/4 there were no formal activities offered on 4/29, 5/1, and 5/3 5/5 - 5/11 the calendar reflected that there would be no formal activities on 5/5, 5/8, and 5/10. However, the white board reflected there would also be no activities on 5/6. On 5/7/2024 at 4:45 PM during an interview the Activity Director said that Monday 5/6 was supposed to be her/his day off but s/he was called in due to the "state" [the survey team] being in the building. When asked about the activities schedule, the Activities Director stated that the Activities Assistant had resigned and s/he was currently the only staff in the activities department. S/he also stated that s/he was working an alternating work schedule of 3 days one week and then 4 the next week. On the days that s/he is not in the building there are are independent activities carts on each wing that include word search, color pencils, and other crafts. When asked about what the residents who were dependent for activities and could use in the cart on the days that there were "Independent Activities", the Activities Director said s/he was not sure. 2.) Observation on 5/7/24 9:50 AM of Resident #73 in their room, this resident was not observed participating in activities. The activity report for this resident for the period of 4/1/24 - 5/7/24 revealed that of the 37 days, the resident had been offered activities for 14 days/activities, S/he did participate in 13 days/activities and one day she refused the offered activity. Review of the activity calendar for April 2024 - May 7th, 2024, there were not activities offered every day or more than one activity per day. This resident is care planned for activities.	F 679		

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The residents care plan stated that s/he is dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] cognitive deficits. The care plan does state that s/he prefers self directed activities and prefers their privacy. The care plan stated, "The resident will maintain involvement in cognitive stimulation, social activities as desired through review date". An intervention listed with this goal was "Assure that the activities the resident attends are: Compatible with physical and mental capabilities; Compatible with known interests and preferences; Adapted as needed (such as large print, holders if resident lacks hand strength, task segmentation), Compatible with individual needs and abilities; and Age appropriate" and "When the resident chooses not to participate in organized activities, offwr [sic] to turn on TV, music in room to provide sensory stimulation. During the day check to see what [proper name omitted] television is on, sometimes [s/he] messes with the remote and gets the channels stuck in the video setting and it needs to be reset back to television channel". Independent activities were not observed with this resident. The objectives of the care plan were not met based on the offering of 14 activities in a period of 37 days.
3.) Per observation and interview on 5/6/2023 at 10:03 AM, Resident #23 was sitting in his/her room with no stimulation. S/He expressed that s/he wishes there were more things to do and that s/he is bored a lot of the time. On 5/8/24 at 11:30 AM, Resident #23 was sitting in his/her room, staring at everyone that walked by in the hall. S/He stated that s/he was bored because there isn't enough going on for activities.

Record review reveals the following activities care

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F 679	Continued From page 29 plan for Resident #23: "The resident is dependent on staff for activities, cognitive stimulation, social interaction," created on 5/3/24, with interventions to "provide a program of activities that is of interest and empowers the resident by encouraging. Allowing choice, self-expression and responsibility." Activities logs from April 1, 2024 through May 6, 2024 reveal that Resident #23 did not participate in 12 of the 36 days reviewed; 4/12/24, 4/14/24, 4/16/24, 4/17/24, 4/19/24, 4/21/24, 4/24/24, 4/25/24, 4/29/24, 5/1/24, 5/3/24, and 5/5/24. Of the 24 days that Resident #23 did participate in activities, the logs reveal only 5 of the days where s/he participated in more than one activity. Per interview on 5/8/24 at 11:42 AM, a Licensed Nursing Assistant (LNA) explained that Resident #23 is often bored because there is not enough for him/her to do and keep him/her entertained. S/He stated that s/he needs more than what is offered for activities.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure that residents	F 684	Resident #2 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility who receive peripheral IV treatments are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure all residents who receive peripheral IV treatments have orders for monitoring peripheral IV sites as well as dressing changes, and that peripheral IVs are care planned.	

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F 684	Continued From page 30 with Peripheral IVs receive treatment and care in accordance with professional standards of practice for the only resident in the facility with a Peripheral IV (Resident #2). Findings include: Per observation on 5/6/24 at approximately 4:00 PM, Resident #2 was observed with a peripheral IV in their left arm. A date of 5/3/24 was written on the IV dressing. Per record review, Resident #2 was ordered for "Cefepime HCl (an antibiotic) Intravenous Solution 1 GM/50ML Use 1 gram intravenously two times a day" for an infection on 5/2/24. There is also orders for "Normal Saline Flush Intravenous Solution 0.9 % Use 10 ml intravenously two times a day" for both pre and post-antibiotic administration, ordered on 5/3/24. There are no orders for peripheral IV monitoring or dressing changes. Per care plan review, there is also no care plan focus for Resident #2's peripheral IV Per review of the facility policy titled "Peripheral IV Dressing Changes" states under the "General Guidelines" section the following: - Change the dressing if it becomes damp, loosened or visibly soiled and at least every 5 to 7 days. Under the "Documentation" section of the policy, it states the following: - The following should be documented in the resident's medical record: o Date, time, type of dressing, and reason for dressing change. Per interview on 5/8/24 at approximately 11:30 AM, the Unit Manager confirmed that Resident #2 should have orders for monitoring of the IV site	F 684	All licensed nurses will be educated on physician's orders and care plan policy and procedure to ensure all residents who receive peripheral IV treatments have orders for monitoring peripheral IV sites as well as dressing changes, and that peripheral IVs are reflected in the care plan. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all residents who receive peripheral IV treatments have orders for monitor peripheral IV sites as well as dressing changes, and that peripheral IVs are reflected in the care plan. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 684 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 684	Continued From page 31 as well as dressing changes, and that the peripheral IV should be reflected in the care plan. When asked why these orders were not placed at the same time as the IV Flush orders, the Unit Manager stated that they assumed that the Peripheral IV would not be in place very long and they never went back to address the missing orders.	F 684		
F 711 SS=E	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that physicians and other providers (as delegated to per regulation) review the Residents' total program of care, including medications and treatments, at each visit as required for 6 of 24 sampled residents (Residents #2, #78, #23, #19, #47, #53). Findings include: 1. Per record review, Resident #2 was admitted	F 711	Residents #2, #78, #23, #19, #47, and #53 continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure all residents have received a regulatory visit, including review of all parts of care, in the past 60 days. Any resident affected will have an updated regulatory visit to review their plan of care. Nurse practitioner and medical director will be educated on regulatory visit requirements to ensure all residents receive required visit. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 to ensure regulatory visit documentation, including review of all parts of care, is completed and substantial compliance maintained.	

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F 711	Continued From page 32 to the facility on 4/18/17. Per review of physician/provider notes from June 2023 through the survey date, there are no provider visit notes during this timeframe that meet the definition of a total program of care review, including a review of all current medications, treatments, and all aspects of the resident's comprehensive plan of care. 2. Per record review, Resident #78 was admitted to the facility on 1/16/23. Per review of physician/provider notes from June 2023 through the survey date, there are no provider visit notes during this timeframe that meet the definition of a total program of care review, including a review of all current medications, treatments, and all aspects of the resident's comprehensive plan of care. 3. Per record review, Resident #23 was admitted to the facility on 10/23/23. Per review of physician/provider notes from October 2023 through the survey date, there are no provider visit notes during this timeframe that meet the definition of a total program of care review, including a review of all current medications, treatments, and all aspects of the resident's comprehensive plan of care. All Nurse Practitioner visits are entered into a form and labeled as "acute visit." There is no way to distinguish if any of these visits meet regulatory requirements because none of them document that all the residents' current medications, treatments, and all aspects of their comprehensive plan of care were reviewed. Attending Physician notes do not list a review of Resident #23's medications. A 12/20/23 Attending Physician note states that Resident #23 is "currently on anticoagulation therapy," even	F 711	The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 711 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 711	Continued From page 33	F 711		

though Resident #23's anticoagulant was discontinued on 12/14/23. A 2/20/2024 Attending Physician note states that Resident #23 is "currently on as needed morphine," even though Resident #23's order for morphine was routine, rather than as needed.

4. Per record review, Resident #19 was admitted to the facility on 10/23/23. Per review of physician/provider notes from June 2023 through the survey date, Nurse Practitioner visit notes during this time frame do not meet the definition of a total program of care review, including a review of all current medications, treatments, and all aspects of the resident's comprehensive plan of care.

5. Per record review, Resident #47 was admitted to the facility on 11/6/23. Per review of physician/provider notes from November 2023 through the survey date, Nurse Practitioner visit notes during this time frame do not meet the definition of a total program of care review, including a review of all current medications, treatments, and all aspects of the resident's comprehensive plan of care.

6. Per record review, Resident #53 was admitted to the facility on 2/16/22. Per review of physician/provider notes from June 2023 through the survey date, Nurse Practitioner visit notes during this time frame do not meet the definition of a total program of care review, including a review of all current medications, treatments, and all aspects of the resident's comprehensive plan of care.

Facility policy titled "Physician Services," with no dates indicating when it was last revised or

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F 711	Continued From page 34 reviewed states "Policy: the policy of this facility to ensure the physician takes an active role in supervising the care of residents. The Physician should: d. Review the resident's total program of care including medications and treatments at each visit. e. Date, write and sign a progress note for each visit. Physicians orders and progress notes shall be maintained in accordance with current OBRA regulations and facility policy." Per interview on 5/08/24 at 3:53 PM, the Director of Nursing confirmed that the Nurse Practitioner notes do not meet the definition of a total program of care review. Per interview with on 5/9/24 at 1:23 PM, the Medical Director confirmed that the provider, whether the Physician or the alternating Nurse Practitioner, is required to review the resident's total program of care at required regulatory visits and document it. S/He stated that s/he was not aware that the Nurse Practitioner was not capturing the information in his/her visit notes. The Medical Director was shown the above policy and stated that s/he had never seen it before and was unsure what the other facility policies the policy referred to. The Medical Director also explained that s/he does not have a system in place to monitor the performance of other health care providers to ensure regulatory requirements are met. See F 841 for more information.	F 711		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a	F 712	Residents #23 and #31 continue to reside at the facility and had no ill effects from this alleged deficient practice.	

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F 712	Continued From page 35 physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure residents are seen by a physician personally, face-to-face, for regulatory visits for 1 of 24 sampled residents (Resident #23), and failed to ensure that regulatory visits were conducted every 30 days for the first 90 days after admission for 1 of 24 sampled residents (Resident #31). The facility also did not have a system in place to track required regulatory visits for any resident. Findings include: 1. Review of Resident #23's Attending Physician regulatory visit dated 12/20/2023 states "Patient was not seen but was discussed with [the Nurse Practitioner]." The note explains that there were no vitals signs taken and no physical exam completed for this visit.	F 712	All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure all new admissions receive a regulatory visit every 30 days for the first 90-days after admission. Physician will complete first regulatory visit within 30-days of admission. Facility will conduct an audit ensuring all residents have a regulatory visit every 60-days after their initial 90-days. These visits may alternate between physician and NP. Any resident affected will have an updated regulatory visit to review plan of care. Unit secretary, nurse practitioner and medical director will be educated on tracking regulatory visits to ensure all residents receive required regulatory visits. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 to ensure regulatory visits are tracked, completed, and substantial compliance maintained. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 712 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 712	Continued From page 36 Per interview 5/08/24 at 3:53 PM, the Director of Nursing confirmed that the above visit would not meet regulatory requirements because it was not in person. 2. The facility did not have a system in place to track regulatory visits as evidenced by the following interviews. Per interview on 5/8/24 at approximately 9:00 AM, the Director of Nursing stated that the Medical Records Specialist was in charge of tracking regulatory provider visits. Per interview on 5/8/24 at 9:49 AM, the Medical Records Specialist explained that s/he keeps track of outside provider visits but does not track required regulatory visits. Per interview on 5/8/24 at 10:19 AM the Administrator confirmed that it should be the Medical Records Specialist's responsibility. Per interview with on 4/9/24 at 1:23 PM, the Medical Director explained that s/he is the attending physician for more than half of the residents at the facility. S/He said that s/he only tracks his/her own required regulatory visits and assumed that the Nurse Practitioner (NP) was performing the alternate required regulatory visits based on the NP expressing that s/he (the NP) will visit every resident in the facility monthly. S/He does not think that the facility has a system to track regulatory visits. S/He explained that s/he did not review other provider visit dates or notes to see regulatory visits met requirements. 3. Per record review Resident #31 was admitted on 2/14/2024 for skilled nursing and rehab services. Review of Physician visit progress notes shows that the resident's Primary Physician conducted a visit on 2/20/2024 and again on 4/23/24. The Nurse Practitioner did record follow up visits on 2/15, 2/20, 2/23, 3/4, 3/8, and 4/9 however, none	F 712		

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F 712	Continued From page 37 of these visits meet the requirements for a comprehensive visit. There is no evidence in the record that the physician conducted a regulatory visit 60 days after admission as required. During an interview on 5/9/2024 at 11:33 AM the Unit Manager (UM) confirmed that Resident #31's attending physician had not seen the resident every 30 days after admission. When asked if there was system in place to monitor physicians visits the UM stated that s/he is not responsible to track the provider visits.	F 712		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F 756	Residents #2, #71, #23 and #19 continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. A house wide audit for the last 90-days will be conducted to ensure all pharmacy recommendations have been reviewed and completed by physician. Licensed nurses, physicians, and nurse practitioner will be educated on the drug regimen review process. The DNS or designee will conduct monthly audits X 3 to ensure all pharmacy recommendations have been reviewed and completed by physician.	

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F 756	Continued From page 38 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 staff interview and record review, the facility failed to ensure that the attending physician documents in the Resident medical record any rationale against, or actions taken as a result of, irregularities identified by the Pharmacist during the monthly medication regimen review for 4 of 5 sampled Residents (Residents #2, #71, #23, and #19). Findings include: 1. Per record review, a pharmacist medication regimen review note from December of 2023 recommends that the physician consider reducing or eliminating Resident #2's Ambien (a sleeping medication) dose due to resident #2's recent falls and the possibility that Ambien could increase fall risk. The physician checked the box "disagree". There is no rationale that can be located in the medical record for Resident #2 explaining why the physician did not want to change the Ambien order. Per interview on 5/8/24 at approximately 11:30	F 756	The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 756 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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AM, the Unit Manager confirmed that there is no evidence of a physician rationale for not wanting to change Resident #2's Ambien order in response to the pharmacist's recommendation.

2. Per record review, a pharmacist medication regimen review note from March of 2024 recommends that the physician obtain a Vitamin D level for Resident #71. The physician checked the box "agree". There is no evidence in the record that the Vitamin D level was ever drawn or ordered for Resident #71.

Per interview on 5/8/24 at approximately 10:45 AM, the Unit Manager confirmed that there is no order for or evidence of a Vitamin D lab draw for Resident #71 in response to the pharmacist's recommendation.

3. Per record review, a pharmacist medication regimen review note for Resident #23 from May of 2024 recommends "currently receiving Morphine 6 times daily. Please evaluate continued need, consider trial taper to 4 times daily, if appropriate." The provider checked the box "disagree". There is no rationale that can be located in the medical record for Resident #23 explaining why the physician did not want to change the Morphine order.

4. Per record review, a pharmacist medication regimen review note for Resident #19 from May of 2024 recommends "currently receiving Oxycodone PRN [as needed] without a stop date. Please evaluate duration of therapy. Consider add stop date of 14 days, if appropriate." The provider checked the box "disagree". There is no rationale that can be located in the medical record for Resident #19 explaining why the physician did not want to change the Oxycodone

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F 756	Continued From page 40 order. Per interview with on 5/9/2024 at 10:47 AM, the Unit Manager confirmed that there should be an indication as to why the provider disagrees with a recommendation documented in the resident's record. Per interview with on 5/9/2024 at 2:14 PM, the NP explained that s/he had been going through the pharmacist recommendations fast and did not know that s/he needed to write additional information in the record.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 757	Residents #23 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. A house wide audit for the last 90-days will be conducted to ensure pharmacy recommendations for unnecessary pain medication were reviewed. Licensed nurses, physicians, and nurse practitioner will be educated on pharmacy recommendations for unnecessary pain medications. The DNS or designee will conduct monthly audits X 3 to ensure pharmacy recommendations for unnecessary pain medication were reviewed.	

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F 757	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 24 applicable residents (Resident #23) remained free from unnecessary medications. Findings include: Per record review, Resident #23 has a physician order for "Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 0.1 ml by mouth every 4 hours for pain, [shortness of breath]. This dosing and frequency has been consistent for Resident #23 since it was first ordered on 1/9/24 and Resident #23's Medication Administration Record reveals that the morphine has been administered as ordered since 1/9/24. Per record review, a pharmacist medication regimen review note for Resident #26 from May of 2024 recommends "currently receiving Morphine 6 times daily. Please evaluate continued need, consider trial taper to 4 times daily, if appropriate." The provider checked the box "disagree". There is no rationale that can be located in the medical record for Resident #26 explaining why the physician did not want to change the Morphine order. Review of Resident #23's vitals, Resident #23 has not reported pain since 2/2/24 and there are no nursing staff or provider evaluations of the effectiveness of the use of morphine or a clinical rationale for the continued administration of the morphine a medication based upon an assessment of the resident's condition and therapeutic goals after that date either. Per interview on 5/07/24 at 9:26 AM, Resident #23's Representative stated that s/he is concerned that Residents #23 is unnecessarily medicated with morphine because Resident #23	F 757	The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 757 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 757	Continued From page 42 does not exhibit pain as they did when they were first prescribed it. See F 657 for more information. Per interview with on 5/8/2024 at approximately 2:30 PM, the Nurse Practitioner, who signed the above pharmacy recommendation stated that s/he has worked at the facility less than a month and was not aware that the family wanted Resident #23 to stop taking the morphine but s/he has not had a provider visit with him/her yet and does not know his/her situation. Per interview on 5/8/2024 at approximately 3:50 PM, the Director of Nursing confirmed that since the NP had never seen Resident #23, there was no way that she could disagree with the dose reduction without doing an evaluation of the Resident. Per a follow up interview on 5/9/24 at 2:14 PM, the Nurse Practitioner explained that s/he had reviewed Resident #23's record and confirmed that s/he should attempt a taper of the morphine medication.	F 757		
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	F 758	Residents #2, #19, and #25 continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents in facility are at risk for this alleged deficient practice. A house wide audit for the last 90-days will be conducted to ensure psychotropic medication GDRs were attempted and addressed with physician as needed.	

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F 758	Continued From page 43 Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that Residents taking	F 758	Physician will be educated on gradual dose reductions and unnecessary psychotropic medications. The DNS or designee will conduct monthly audits X 3 to ensure psychotropic medication GDRs are attempted and addressed with physician as needed. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 758 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 758	Continued From page 44 psychotropic medications receive gradual dose reductions, unless contraindicated, for 3 of 5 sampled Residents (Residents #2, #25, #19). Findings include: 1. Per record review, Resident #2 is receiving Venlafaxine Extended Release Tablets 150 mg in the morning and 37.5 mg before bed every day. This dosing has been consistent for Resident #2 over the last year. Per review of pharmacist monthly MRRs (Medication Regimen Reviews) for the past year, there is no evidence that a GDR (gradual dose reduction) for Venlafaxine was ever discussed. There is also no documentation from Resident #2's Provider regarding any contraindications for attempting a GDR for Venlafaxine. Per interview on 5/8/24 at approximately 11:30 AM, the Unit Manager confirmed there is no evidence of any consideration of a GDR of Venlafaxine for Resident #2 in the last year, and stated that the facility "doesn't generally consider doing GDRs for antidepressants". Per interview on 5/9/24 at approximately 12:15 PM, a pharmacist (subcontracted by the company that the facility furnishes its pharmaceutical services from) stated that, in general, antidepressant medications are considered inappropriate for GDRs, as they are usually associated with chronic enduring conditions. For this reason, the pharmacist confirmed that they do not alert the physicians via MRRs to consider GDRs for any psychoactive medication that is prescribed for a chronic enduring medical condition. When asked if the appropriateness of a GDR should be up to the pharmacist or the physician, the pharmacist replied that they	F 758		

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F 758	Continued From page 45	F 758		

assume that the physician thinks a GDR is contraindicated when they don't change the dosage of the medication. They could not find any evidence of an explicit rationale for GDR contraindication from the physician in the record.

Per interview with the pharmacist on 5/9/24 at approximately 12:45 PM, the pharmacist confirmed that Resident #2 (as well as Residents #73, #25, #19) would not have had a GDR suggested in an MRR per their company's practice.

Per interview on 5/9/24 at approximately 1:30 PM, the Medical Director confirmed that they were not aware of GDR requirements and that the pharmacists were not tracking them for psychotropic medications prescribed for chronic enduring medical conditions.

2. Per record review, Resident #19 has physician order for the following psychotropic medication "50 mg Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER." This dosing has been consistent for Resident #19 over the last year. Per review of pharmacist monthly MRRs for the past year, there is no evidence that a GDR for Sertraline was ever discussed. There is also no documentation from Resident #19's attending physician or prescribing providers regarding any contraindications for attempting a GDR for Sertraline.

Per interview on 5/9/24 at 1:23 PM, Resident #19's Attending Physician, who also serves as the Medical Director for the facility, explained that s/he thought by indicting in his/her visit notes that the medications were to be continued was enough to demonstrate that s/he did not want to

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F 758	Continued From page 46 attempt a gradual dose reduction. S/He explained that s/he was unaware that the regulation requires the attending physician or prescribing practitioner to identify and document clinical contraindications if a GDR is not to be attempted and had never seen a policy regarding the regulatory requirements for psychotropic medications. 3. Per record review Resident #25 is receiving clozapine (antipsychotic) 250 MG at bedtime for schizophrenia and venlafaxine 75 MG twice daily for depression. This dosing has been consistent for Resident #25 over the last year. Per review of pharmacist monthly MRRs (Medication Regimen Reviews) for the past year, there is no evidence that a GDR (gradual dose reduction) for clozapine or venlafaxine was ever recommended. There is also no documentation from Resident #25's Provider regarding any contraindications for attempting a GDR for the clozapine of venlafaxine. Per interview on 5/9/2024 at 11:30 AM with the Unit Manager the physicians are not required to attempt a GDR for residents who are diagnosed with schizophrenia. The Unit Manager confirmed that there was no evidence that a GDR had been considered.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 760	Resident #23 continues to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice.	

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F 760	Continued From page 47 failed to ensure 1 of 24 sampled resident (Resident #23) are free from significant medication errors. Findings include: Per record review Resident #23 was admitted on 10/23/23 for rehabilitation following a hospital stay related to a urinary tract infection and sepsis. S/He has diagnoses that include heart failure, pacemaker, chronic pulmonary embolism (a blood clot that forms a blockage in the artery of the lung), and lung cancer. Per interview on 5/07/24 at 9:26 AM, Resident #23's Representative explained that s/he was concerned that Resident #23 did not receive his/her anticoagulant for weeks, around the time when Resident #23 had a significant decline in his/her health. S/He explained that Resident #23 had been seeing a hematologist who had been treating his/her history of blood clots with anticoagulants for a long time. The Representative stated that no one had alerted him/her to the discontinuation of the anticoagulant and s/he became aware that Resident #23 was no longer on an anticoagulant only when s/he was reviewing a list of charges from the facility. When s/he asked the facility staff why Resident #23 was no longer on it, s/he could not get an answer. Per Resident #23's 10/23/23 Transfer of Care note, discharge medications reveal the following order listed under "continue," "enoxaparin [Lovenox; an anticoagulant, used to prevent and treat blood clots] 120 mg/0.8 mL injection, inject 120 mg into the skin for 90 days." A majority of the medication orders on this discharge list are prescribed for 90 days or have a 90 day supply listed. A 11/1/23 Attending Physician note reveals	F 760	A house wide audit for the last 30-days will be conducted to ensure medication orders were updated on resident return. Licensed nurses and medical providers will be educated on medication review on resident return. The DNS or designee will conduct random weekly audits X 4 and monthly X 2 to ensure medication orders are updated on resident return. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 760 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 760	Continued From page 48 that related to Resident #23's diagnoses of pulmonary embolism. Resident #23 is currently on Lovenox daily and s/he is being followed by hematology. A 11/30/23 Hematology progress note reveals that Resident #23 is to continue his/her anticoagulant, Lovenox, daily. The physician order for the anticoagulant enoxaparin sodium (Lovenox) ended on 12/14/23 and a new order was never placed. A 12/20/23 Attending Physician note reveals that Resident is "currently on chronic anticoagulation therapy" and recommendations to monitor blood test periodically for management of anticoagulant use. A review of Resident's Medication Administration Record from December 2023, January 2024, and February 2024 reveal that Resident #23 did not receive Lovenox, or any other anticoagulant for 49 days, from 12/14/23 to 2/2/24. A 2/2/24 nursing note reveals that hematology should be restarted on Lovenox. Per interview on 5/9/24 at approximately 2:30 PM, the Director of Nursing was unable to explain why the order for Lovenox was stopped on 12/14/23. Per interview on 5/9/2024 at 3:46 PM, the Medical Director confirmed that Resident #23's order for Lovenox should not have stopped on 12/14/23.	F 760		
F 804 SS=F	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- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;	F 804	Resident #26 continues to reside at the facility and had no ill effects from this alleged deficient practice. Resident #77 discharged from the facility on May 7, 2024. Resident #187 discharged from the facility on May 17, 2024. Resident #243 discharged from the facility on May 6, 2024.	

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F 804	Continued From page 49 §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, resident interviews, staff interviews, and record review, the facility failed to ensure that food served to Residents is palatable, attractive, and at an appetizing temperature. Findings include: Per observation on 5/6/24 at approximately 12:30 PM, Resident #77 was exerting much energy and struggling to cut a chicken patty served to them for lunch with a metal fork and knife. Resident #77's roommate, Resident #243, was eating the chicken patty uncut with their hands. When asked why they were eating the patty this way, Resident #243 stated that it was difficult to cut and "hard as a rock". Resident #243 then proceeded to bang the side of the patty on their bedside table and it made a hard clunking sound. On 5/6/24 at approximately 12:45 PM, this surveyor requested a lunch tray from both the Wing 1 steam table and the dining room steam table. Both trays were prepared after all other resident meals were plated and placed on the last meal cart sent to the units. The test trays were then sampled after the last resident on the last meal cart for each steam table was served. The chicken patty on the Wing 1 test tray was very dry and hard. It took an excessive amount of effort by this surveyor to cut through the patty with a fork and a knife. On 5/6/24 at approximately 1:15 PM, the Administrator was shown the chicken patty served on the Dining Room test tray and	F 804	All residents in the facility are at risk for this alleged deficient practice. Administrator or designee will randomly observe meal services to ensure food served was palatable and appetizing. Test trays were taken to ensure all food being served was at appropriate temperatures. All staff will be educated on the importance of residents receiving meals that are palatable, attractive and at required temperatures. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all residents receiving meals that are palatable, attractive and at appropriate temperatures. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 804 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 804	Continued From page 50	F 804		

observed this surveyor snapping it in half. It was very dry and crumbly on the inside. When asked if the Administrator thought that this was an appetizing or acceptable meal for Residents, the Administrator replied "no".

For the dinner service on 5/6/24, a test tray was requested from the Wing 1 Steam Table to be prepared after all other resident meals were plated and placed on the last meal cart sent to Wing 1A (the wing where Residents #26, #187, #77, and #243 were residing).

Per interview on 5/6/24 at approximately 4:00 PM, Resident #26 stated that the food served to them is "cold and gross all the time". The same day at 5:15 PM, Resident #26 was served their dinner meal and stated that it was cold and unappetizing.

Per interview and observation on 5/6/24 at approximately 5:30 PM, Resident #187 had a hamburger with French fries served to them in their room. As soon as the resident was served and the plate cover was removed, a surveyor asked if it would be ok if they obtained the temperature of the hamburger with a clean thermometer before they started eating. Resident #187 agreed. Per the obtained temperature, Resident #187's hamburger was served at 91.8 degrees F. The human body typically runs about 98.6 degrees F, so this hamburger would not feel warm to taste. Resident #187 confirmed that the burger was cold and they would not be eating it.

The Wing 1A test tray was then sampled at approximately 5:35 PM after the last resident on Wing 1A was served. The hamburger was 106.5 degrees F. At this time, the Administrator

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F 804	Continued From page 51 confirmed that this was not a palatable temperature for hot foods. On 5/6/24 at 5:38 PM, the burgers in the Wing 1 steam table had their temperature taken by a surveyor. The burgers were 129.5 degrees F at their hottest point. Dietary Assistant #1, who was working the Wing 1 steam table, stated that hot foods were expected to go into the steam table at temperatures of at least 165 degrees F and be held between 135 and 145 degrees F while on the steam table. However, Dietary Assistant #1 confirmed that they do not take temperatures of foods on the steam table before plating and that they do not carry thermometers with them to the units. Dietary Assistant #1 stated that the steam table has hot water compartments that need to be fully covered by appropriately sized food trays in order to keep the heat in. They explained how this steam table had come up without the proper sized trays, so there was a large gap between trays where steam was escaping and not keeping the food as hot. At this time, the Dietary Manager confirmed that these burgers needed to go back down to the kitchen for reheating to be served at a palatable temperature. On 5/6/24 at approximately 5:40 PM, the burgers in the dining room steam table had their temperature taken by a surveyor. These burgers were 107.5 degrees F at their hottest point. Dietary Assistant #2, who was working the dining room steam table, confirmed that these temperatures were too low for holding food and proceeded to bring them down to the kitchen for reheating. They also confirmed that the dining room steam table was set up the same way as the Wing 1 steam table, allowing for heat to escape between improperly sized food trays in	F 804		

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F 804	Continued From page 52 the steam table compartments. Per interview on 5/6/24 at approximately 6:00 PM, the Dietary Manager confirmed that the facility is not consistently serving food to Residents that is palatable, attractive, and at an appetizing temperature.	F 804		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interview and record review, the facility failed to ensure that residents were served a nourishing snack at bedtime when the time between dinner and breakfast the following morning is more than 14 hours. The facility also failed to ensure that the Resident Council agrees	F 809	All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure residents are being offered a HS snack Licensed nurses, licensed nursing assistants and all dietary staff will be educated on HS policy, procedure and the importance of residents receiving HS snacks. Administrator or designee will conduct random weekly audits X 4 and monthly X 2 to ensure all residents receiving HS snacks as per policy. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 809 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 809	Continued From page 53	F 809		

to this amount of time between dinner and breakfast the following morning. Findings include:

1. Per review of the facility meal schedules, Residents are served breakfast at 8:00 AM and Dinner at 5:00 PM. There are 15 hours that elapse between the dinner meal and the breakfast meal the following morning.

Per interview on 5/7/24 at approximately 4:00 PM, the following Residents were interviewed regarding bedtime snacks:

- Resident #187, admitted on 5/1/24 with a BIMS (Brief Interview of Mental Status Score) of 13 (cognitively intact), stated that they have never been offered a snack before bed by staff.
- Resident #240, admitted on 4/26/24 with a BIMS of 15 (cognitively intact), stated that they have never been offered a snack before bed by staff.
- Resident #82, admitted on 4/10/24 with a BIMS of 15 (cognitively intact), stated that they have never been offered a snack before bed by staff.
- Resident #80, admitted on 11/8/23 with a recent BIMS of 7 (moderate-high mental impairment) stated that they don't recall being offered a snack before bed since being in the facility.

2. Per resident council meeting on 5/8/24 at 10 AM with resident #'s 15, 18, 50, 51, and 53, all stated that snacks are not offered to residents, they need to ask if they want a snack. Resident #54 stated they are diabetic and are "not offered anything to help keep my sugar up throughout the night". They stated that "luckily I haven't had any issues with my morning sugars". Surveyor asked the attendees if the staff discussed with them the

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F 809	Continued From page 54 time frame between the dinner/supper meal to breakfast the following morning. Resident #54 (Resident Council Co-President) stated there has been no discussion with the resident council group or either co-president regarding the length of time between dinner/supper and breakfast the following morning. Several attendee's stated they didn't know there was a regulation specific to the length of time allowed between dinner/supper and breakfast. The regulation was discussed and all attendees again stated this was not discussed with them or brought up at any resident council meeting. Review of Resident Council meeting minutes from 1/2024 - 4/2024 did not reveal any resident rights discussions/education. There are no notes specific to meal times as they relate to the length of time between dinner/supper and the following mornings breakfast. Interview on 5/8/24 at approximately 1:45 PM with the facility administrator regarding the residents statements specific to snacks not being offered, the administrator stated to their knowledge snacks were being offered and are documented as such by the LNA's (Licensed Nurses Aids) on each residents task sheet in their EHR (Electronic Health Record). The administrator confirmed the dinner/supper meal is more than 14 hours to the next breakfast meal and s/he was not aware whether this had been discussed with resident council.	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	All residents in the facility are at risk for this alleged deficient practice.	

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F 812	Continued From page 55 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Per observation, staff interview, and record review, the facility failed to ensure that it stores and prepares food in accordance with professional standards for food service safety. Findings include: 1. Per an initial tour of the facility kitchen on 5/6/24 at approximately 9:30 AM, the following conditions were observed: - The reach-in refrigerator had a large container of bulk iced tea with a "use by" date of 5/4/24. - A steam table had dried, crusted food drippings on the bottom shelf as well as an unlabeled bag of hamburger buns with copious amounts of condensation on the inside of the bag. - Two food prep tables used for the breakfast service were no longer in use and had spilled milk, dropped applesauce, and copious amounts of crumbs spread across them. - A small table on the far wall of the kitchen was	F 812	1) An audit will be completed to ensure all food is being stored and labeled, and the entire kitchen environment, including, but not limited to, steam tables, prep tables, floors, walls, etc. are in accordance with professional standards for food service safety. Dietary staff will be educated on storage and labeling of food, as well as cleanliness of environment per policy to remain in accordance with professional standards for food service safety. Administrator or designee will conduct audits weekly x 4 weeks and random monthly audits X 2 months to evaluate whether food is being stored and labeled appropriately, and to ensure environment cleanliness remains in accordance with professional standards for food service safety. The audit results will be reviewed at QAPI for further interventions. 2) When administrator learned that the only egg option available to order on the dietary order guide was unpasteurized eggs, s/he reached out to the regional dietician as well as the US Food representative to have pasteurized eggs added to the order guide. Pasteurized eggs were added to the dietary order guide; unpasteurized no longer available.	

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F 812	Continued From page 56 covered with food particles, an opened container of peanut butter with the lid askew, a pan of melted margarine/butter with a spoon inside, an opened bag of sliced bread, as well as other kitchen implements and clean containers. - The floors of the kitchen were dirty with dried spills, food particles, small pieces of trash, and dirt in excess of what a floor would accumulate over the span of a few hours. - Several oven racks were propped up on the side of the oven with one side resting on the dirty floor. - Clean knives were on a magnetic holder mounted above a sink. There were orange oily drops of an unknown substance all along the walls around the clean knives. The drop ceiling panel directly above the knives was also saturated with the same orange oily substance as the walls. - The sink below the clean knives contained an assortment of items - a dirty whisk, a dirty glass tray, a dirty scale, and a shaker of cinnamon with a loose piece of plastic wrap over the top. - In the walk-in refrigerator there were two pieces of prepared cake without any labels or dates, half of a cut watermelon wrapped in plastic wrap with no labels or dates, and a bag of cubed turkey pieces with no labels or dates. Per interview on 5/6/24 at approximately 9:45 AM, the Dietary Manager confirmed the above observations and that there is general disorganization/uncleanliness in the kitchen. The Dietary Manager stated that the staff in the kitchen had recently had an inservice about cleaning expectations, but that there was no assigned cleaning schedule or check-off list for cleaning tasks. Per review of the kitchen's general cleaning	F 812	Dietary staff will be educated on not utilizing unpasteurized eggs. Dietary manager will be educated on not ordering unpasteurized eggs, and if pasteurized eggs are not available, they are to notify the administrator. Administrator or designee will conduct random weekly audits X 4 weeks and random monthly audits X 2 months to ensure unpasteurized eggs are not being served in the facility. Date of completion: June 20, 2024 **Tag F 812 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 812	Continued From page 57 schedule, small equipment, appliances, counters, carts/trucks, and kitchen floors are to be cleaned after each use. Kitchen floors are also expected to be cleaned in their entirety on a daily basis. 2. Per an initial tour of the facility kitchen on 5/6/24 at approximately 09:45 AM, the walk-in refrigerator contained a box of raw eggs. The box was labeled "cage free organic, raw eggs" with no label indicating that they were pasteurized (warmed to a temperature that reduces the risk of bacteria in the eggs). Dietary Assistant #3 confirmed at this time that the box does not indicate that the eggs are pasteurized. Per review of the kitchen's food vendor order, there is no option for pasteurized eggs approved by the corporate office for the facility to order. The eggs that the facility has been ordering are unpasteurized. Per interview on 5/6/24 at approximately 9:45 AM, the Dietary Manager stated that they had always thought that their egg order was for pasteurized eggs and that they have 5 Residents a day who order and receive over-easy eggs for breakfast. They confirmed that serving Residents undercooked unpasteurized eggs puts them at risk for food borne illness.	F 812		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and	F 837	Staff's inability to access to policies and procedures was remedied immediately. A generic login was given to the facility for all staff. An audit of all staff computers will be conducted to ensure appropriate access was available.	

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F 837	Continued From page 58 §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility Governing Body failed to ensure that facility policies were accessible to all staff members operating the facility and providing care to the facility's residents. This has the potential to affect all residents in the facility. Findings include: Per facility policy titled "Governing Body," [undated], states "the Governing Body is responsible for establishing and implementing policies regarding management and operation of the facility." Per interview on 5/08/24 at 12:58 PM, the Administrator was unable to access all facility policies. When asked how facility staff access policies, the Administrator explained that they would get them through the cooperate leadership team. S/He explained that policies are on the desktop computers but staff do not have access to them. S/He explained that it has always been that way and his/her "corporate" is aware of this issue. Per interview on 5/9/23 at 11:51 AM, a Licensed Practical Nurse was asked to pull up facility policies. S/He explained that, while in theory s/he should be able to access all care polices, s/he is	F 837	All staff will be educated on how to access the company's policies and procedures. Directions on how to find policies, as well as the generic username and password are available to all staff on the units. This education will be provided in orientation to ensure all new staff are aware procedure. Administrator or designee will conduct random weekly audits X 4 weeks and random monthly audits X 2 months to evaluate whether staff are aware of how to access company policies and procedures. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 837 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 837	Continued From page 59 unable to access them on the computer. Per interview on 5/9/2024 at 11:52 AM, the Unit Manager explained that policies are not easy to navigate and was unable to provide this surveyor with the physician service policy. S/He explained that if a nurse needs a policy, the nurse would have to reach out to the clinical on-call person. S/He would have to got to the Director of Nursing or the Administrator for the policy. Per interview on 5/09/24 at 3:15 PM, the Social Service Director was asked to produce policies but was unable to because s/he did not have access to them. Per interview on 5/09/24 at 2:22 PM, the Administrator explained that s/he has quarterly calls with the governing body. S/He explained that the governing body was aware of the issues with accessing the policies. When asked for the contact information for the governing body, s/he gave the surveyor the Regional Vice President of Operations' (RVPO) name and phone number. On 5/09/24 at 4:09 PM, the Regional Vice President of Operations was contacted by phone for an interview. During this interview, the RVPO refused to answer this surveyor's questions regarding facility policies. The RVPO indicated that s/he would not answer any questions from this surveyor and the Administrator would represent the governing body moving forward. Per interview on 5/9/24 at 4:32 PM, the Administrator explained that facility policies are not managed by the facility; they are managed by the Regional Clinical Director. S/he explained that the facility policies are generic, not facility	F 837		

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F 837	Continued From page 60 specific, and are updated by the regional team. The facility gets notified by email if they have been updated. S/He explained that s/he was not aware of a facility policy that addresses the management or use of policies. At approximately 5:15 PM, the Administrator produced the following policy and confirmed that this was the only one. Facility policy titled "Administrative Protocols," effective 3/2015 states "The facility will have manuals/protocols/programs to meet the needs and services required by the resident that are reviewed, updated and approved at least annually. Electronic availability of policies, procedures or programs meets this requirement ... The following Manuals/Guides will be available at the facility [the policy lists 17 different types of manuals that should be at the facility including the administrative manual, the nursing manual, and the pharmacy manual]." The Administrator confirmed that policies are not available to staff as stated in the above policy.	F 837		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must	F 838	All residents in the facility are at risk for this alleged deficient practice. Administrator will be educated on the facility assessment and ensure it is reviewed by the medical and governing body. Administrator will review the facility assessment with the medical director and governing body. The facility assessment will be reviewed and updated by the administrator, governing body and medical director on a quarterly basis.	

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F 838	Continued From page 61 address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(a)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and	F 838	Date of completion: June 20, 2024 **Tag F 838 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 838	Continued From page 62 (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility assessment the facility failed to ensure that the required individuals including a representative of the governing body and the medical director were involved in the development of the facility assessment. This has the potential to affect all residents. Findings include: Per review of the facility assessment last updated on 4/9/2024, persons involved in completing the assessment lists: Administrator [name omitted] LNHA (Licensed Nursing Home Administrator); Director of Nursing: [name omitted] RN (Registered Nurse); Governing body Representative: LNHA; Medical Director: MD. Per interview on 5/09/24 at 1:23 PM, the Medical Director stated that s/he has not been involved in developing, reviewing, or revising the facility assessment. Per interview with the Administrator on 5/9/24 at 4:33 PM, s/he explained that the governing body is not involved in developing the facility assessment. The Administrator stated that s/he does report when the facility assessment was last updated during compliance calls with the governing body. The Administrator also	F 838		

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F 838	Continued From page 63 confirmed that the medical director was also not involved in the development of the facility assessment.	F 838		
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility policies, the facility failed to ensure that the Medical Director fulfilled his/her responsibility to coordinate medical care with facility providers and assist the facility with the development and implementation of resident care policies. This deficient practice has the potential to affect all residents residing in the facility. Findings include: Facility policy titled "Medical Director Responsibilities," dated 2023, states "4. The Medical Director's responsibilities include participation in: a. Administrative decisions including recommending, developing and approving facility policies related to resident care of physical, mental and psychosocial well-being; c. Organizing and coordinating physician services and services provided by other professionals as they relate to resident care; 8. Medical Director will assist in the development of systems to monitor the performance of the	F 841	Residents #2, #78, #23, #19, #47 and #53 continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. Physician will be educated on the implementation of resident care policies and the coordination of medical care within the facility. Medical director will be responsible for overseeing all physicians who provide care to residents in the facility and ensuring they remain complainant within regulatory requirements Physican will be made aware of any policy or regulatory changes on a monthly basis during QAPI meetings. Medical director will conduct random monthly audits X 3 to ensure physicians providing care to residents remain compliant with regulatory requirements. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024	

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F 841	Continued From page 64 health care practitioners including ... ensuring other licensed practitioners (e.g., nurse practitioners) who may perform physician delegated tasks act within the regulatory requirements and within the scope of practice as defined by State law." Per review of provider notes, both Attending Physician and Nurse Practitioner notes, for Residents #2, #78, #23, #19, #47, #53, multiple required regulatory visit notes did not meet the definition of a total program of care review, including a review of all current medications, treatments, and all aspects of the resident's comprehensive plan of care. See F711 for more information. Review also showed that Resident #23 was not actually seen during a regulatory visit on 12/20/23. See F712 for more information. The facility policy titled "Physician Services," with no dates indicating when it was last revised or reviewed, states "Policy: the policy of this facility to ensure the physician takes an active role in supervising the care of residents. The Physician should: a. New/re admission are preferably seen within 2 to 7 days of admission to the facility. b. See resident within 30 days of initial admission to the facility. c. The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least 60 days thereafter by physician or physician delegate as appropriate by State law. Physician visit- frequency of visits, emergency care of residents, etc. are provided in accordance with current OBRA regulations and facility policy. Consultative services shall be made available for community based consultants or from a local	F 841	**Tag F 841 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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hospital or medical center.
d. Review the resident's total program of care including medications and treatments at each visit.
e. Date, write and sign a progress note for each visit. Physicians orders and progress notes shall be maintained in accordance with current OBRA regulations and facility policy."

The above policy was presented to the surveyor on 5/7/2024. The surveyor asked the Administrator to produce the facility policies that the "Physician Services" policy referred to in the two times mentioned above. Per interview on 5/08/24 at 12:58 PM, the Administrator was still unable to produce additional policies about physician services because they were unable to access all the facility polices.

Per interview on 5/9/2024 at 1:23 PM, the Medical Director was shown multiple facility policies, including the above policy titled "Physician Services." S/He explained that s/he had never seen this policy before but was aware of the requirement that regulatory visits are to include a review the resident's total program of care including medications and treatments. When asked about additional facility policies, as mentioned in the above policy, s/he explained that s/he does not have access to the facility's policies. When asked if s/he was aware that the Nurse Practitioner's visit notes did not demonstrate that each resident's total program of care was reviewed at regulatory visits, s/he said s/he was not aware. The Medical Director also explained that s/he does not have a system in place to monitor the performance of other health care providers to ensure regulatory requirements are met, including tracking regulatory provider

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F 841	Continued From page 66 visits. S/He confirmed that all regulatory visits by a resident's physician and the nurse practitioner need to review the resident's total program of care and be in person.	F 841		
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; (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,	F 842	Residents #23 and #31 continue to reside at the facility and had no ill effects from this alleged deficient practice. All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure all residents have a regulatory provider chart note. Education will be provided to the unit secretary on uploading timely provider visit notes into resident charts. DNS or designee will conduct random monthly audits X 3 to ensure all residents have a regulatory provider chart note. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 842 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 842	Continued From page 67 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that records are complete, accurately documented, readily accessible, and systematically organized related to physician notes for 2 of 27 sampled residents (Residents	F 842		

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	475037	A. BUILDING _____ B. WING _____	C 05/09/2024

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F 842	Continued From page 68 #23 and #31). Findings include: 1. Per review of Resident #23's medical record, the following provider visits were missing from the resident's medical record: -A 11/30/23 Hematology progress note revealing that Resident #23 is to continue his/her anticoagulant, Lovenox, daily. The physician order for the anticoagulant enoxaparin sodium (Lovenox) ended on 12/14/24 and a new order was never placed. A 2/2/24 nursing note reveals that hematology should be restarted on Lovenox. See F760 for more information. -A 12/21/2023 Emergency Department provider note, revealing that Resident #23 was being seen related to an accidental or unintentional opiate overdose that the facility just started to administer. This information is not addressed in any other facility nursing note or facility provider note. - 2/20/24 and 4/23/24 attending physician notes. 2. Per record review Resident #31 was admitted to the facility on 2/14/24. There was no evidence of Physician visit notes present in Resident #31's medical record. During an interview on 5/09/24 at 11:33 AM the Unit Manager confirmed that the Physicians notes were not located in Resident #31's medical record. The Unit Manager later provided this surveyor with copies of Physician's visit notes dated 2/20/24 and 4/23/24. Per interview on 5/09/24 at approximately 3:30 PM, the Medical Records Specialist confirmed that the above residents did not have all their provider visits uploaded and scanned into their medical record.	F 842		

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F 848 SS=B	Binding Arbitration Agreements CFR(s): 483.70(n)(2)(iii)(iv)(6) §483.70(n)(2) The facility must ensure that: (iii) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties; and (iv) The agreement provides for the selection of a venue that is convenient to both parties. §483.70(n)((6) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute on and be available for inspection upon request by CMS or its designee. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that binding arbitration agreements provide for the selection of a neutral arbitrator and a location convenient to both parties for 2 of 3 sampled Residents (Residents #67 and 41). Findings include: 1. Per record review, Resident #67 was admitted to the facility on 3/14/23. The signed binding arbitration agreement in Resident #67's chart was signed by the Resident's Representative on admission to the facility. The agreement contains the following language: "All Arbitrations shall be administered by ADR Options, Inc. in accordance with the ADR Operations Rules of Procedure. ...Arbitration proceedings will be conducted at a local site either at the facility or a site selected by the Facility within ten miles of the facility."	F 848	Residents #67 and #41continue to reside at the facility and had no ill effects from this alleged deficient practice. Any resident admitted to the facility prior to April 2023 are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure all residents admitted to the facility have the current arbitration agreement to ensure compliance with policy. Any resident who has an outdated arbitration agreement will be presented with the updated version; they can decide if they want to participate or not. Administrator or designee will conduct random weekly audits X 4 weeks and random monthly audits X 2 months to ensure all residents have the most up to date arbitration agreement uploaded in their profiles. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024 **Tag F 848 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 848	Continued From page 70 2. Per record review, Resident #41 was admitted to the facility on 3/8/23. The signed binding arbitration agreement in Resident #41's chart was signed by the Resident's Representative on 3/9/23. The agreement contains the following language: "All Arbitrations shall be administered by ADR Options, Inc. in accordance with the ADR Operations Rules of Procedure. ...Arbitration proceedings will be conducted at a local site either at the facility or a site selected by the Facility within ten miles of the facility." Per interview on 5/7/24 at approximately 3:00 PM, the administrator confirmed that the signed arbitration agreements for Residents #67 and #41 did not contain the required language permitting the selection of a neutral arbitrator and a location convenient to both parties.	F 848		
F 880 SS=F	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,	F 880	1) Resident #24 continues to reside at the facility and had no ill effects from this alleged deficient practice. All resident in the facility is at risk for this alleged deficient practice. A house wide audit will be conducted to ensure any resident on droplet isolation precautions has masking requirements being offered and documented. Education to all staff will be provided on droplet isolation and masking requirements.	

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F 880	Continued From page 71 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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	F 880	Infection preventionist or designee will conduct random weekly audits X 4 and monthly X 2 to ensure any resident on droplet isolation precautions has masking requirements documented. The audit results will be reviewed at QAPI for further interventions. 2) All residents in the facility are at risk for this alleged deficient practice. A house wide audit will be conducted to ensure glucometers are cleaned with the appropriate cleaning solution, and that the cleaning solution is accessible. Education will be provided to all licensed nurses to ensure glucometers are being cleaned with the appropriate cleaning solution. Infection preventionist or designee will conduct random weekly audits X 4 and monthly X 2 to ensure glucometers are cleaned with the appropriate cleaning solution, and that the cleaning solution is accessible. The audit results will be reviewed at QAPI for further interventions. Date of completion: June 20, 2024	

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F 880	Continued From page 72 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections as evidenced by the improper use of PPE (personal protective equipment) for 1 resident on precautions (Resident #24) and the failure to implement infection prevention practices related to blood glucose monitoring. Findings include: 1. Per record review, Resident #24 has physician orders dated 5/7/24 that read: "Contact and Droplet Precautions related to respiratory cold symptoms one time only for 7 days." [Contact precautions [are] Used for patients/residents that have an infection that can be spread by contact with the person's skin, mucous membranes, feces, vomit, urine, wound drainage, or other body fluids, or by contact with equipment or environmental surfaces that may be contaminated by the patient/resident or by his/her secretions and excretions ...Droplet precautions [are] used for patients/residents that have an infection that can be spread through close	F 880	**Tag F 880 POC accepted on 6/14/24 by S. Stem/P. Cota**	

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F 880	Continued From page 73 respiratory or mucous membrane contact with respiratory secretions. (Transmission-Based Precautions - HAIAR (virginia.gov)].Per employee interview on 5/7/24 at 10:55 AM, a Licensed Practical Nurse [LPN] confirmed that residents with contact and/or droplet precautions should wear a mask outside of their room. Per record review of the facility's "Isolation - Multi Route Transmission-Based Precautions" policy [revised 2018] under 'Droplet Precautions' the policy reads "A mask will be placed on the resident during transport from his or her room." Per observation on 5/7/24 at 1:38 PM Resident #24 was seen sitting in a wheelchair in the hallway and common area without a mask on. Per observation on 5/8/24 at 9:30 AM Resident #24 was sitting in a wheelchair at the unit's nurses' station without a mask on next to another resident who was not wearing a mask. An interview was conducted with the facility's Infection Preventionist Nurse on 5/8/24 at 11:32 AM. Per interview the facility's Infection Preventionist Nurse confirmed Resident #24 had tested positive for "Parainfluenza III" [Parainfluenza virus type 3 is one of a group of common viruses known as human parainfluenza viruses (HPIV) that cause a variety of respiratory illnesses ...HPIVs are usually spread from an infected person to others through coughing, sneezing, and/or touching. (https://rarediseases.org/gard-rare-disease/parainfluenza-virus-type-3/)]. The Infection Preventionist Nurse confirmed Resident #24 was on droplet precautions and should be wearing a mask when outside his/her room. The Infection Preventionist Nurse confirmed there was no documentation in Resident #24's medical record that the resident was offered and/or refused to wear a mask	F 880		

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F 880	Continued From page 74 related to the droplet precautions. 2. Per observation on 5/7/24 at approximately 9:30 AM, LPN 9 was observed doing a medication pass for a Resident receiving insulin. This administration required them to obtain the Resident's blood sugar. After the blood sugar was obtained, LPN 9 proceeded to clean the glucometer (a device that measures the amount of sugar in a person's blood) with an isopropyl alcohol swab. Per interview following this observation, LPN 9 stated that they believed that they were instructed to clean the facility glucometers with isopropyl alcohol swabs during training. They confirmed that the facility has one glucometer per medication cart, that it is used on multiple residents, and it is expected to be cleaned after each use before being used on another Resident. Per review of the manufacturer's cleaning instructions for the glucometer, there are two approved methods to sufficiently clean the glucometer to prevent the transmission of bloodborne pathogens: Option 1 - Obtain a commercially available EPA (Environmental Protection Agency)-approved disinfectant detergent or germicidal wipe. Option 2 - Clean the outside of the glucose meter with a lint-free cloth dampened with soapy water OR isopropyl alcohol (70-80%). - Disinfect the meter by diluting 1 mL of household bleach in 9 mL water to achieve a 1:10 dilution.	F 880		

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F 880	Continued From page 75 Per interview on 5/7/24 at approximately 10:30 AM, the Unit Manager confirmed that cleaning the glucometer with isopropyl alcohol alone does not sufficiently disinfect the glucometer to prevent the transmission of bloodborne pathogens.	F 880		