STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435132	A. BUILDING _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	A Federal Monitoring Comparative Survey was conducted by the Centers for Medicare & Medicaid Services (CMS), following the State Agency Survey 3/3-3/6/24. Refer to Event ID: LW9E11. Event ID: X9SK11 Survey Dates: 4/8-4/11/24. Facility Census: 44			
F 585 SS=F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585	All policies regarding grievances were reviewed and will update as needed. Administrator or designee has updated grievance log along with the grievance form to show to staff, residents, and families. Staff educated on grievance policy and how to report to Grievance Officer. Resident and family were educated on policy as well by letter. All resident could be affected. Those affected were addressed and resolved. Administrator or designated staff will audit weekly for 4 weeks, then monthly for two months. Will take to QAPI for review and will be reviewed by Medical Director. Completion date: 05/01/2024 with ongoing audits	05/01/2024

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

Kathleen Styles | Administrator | 05/16/24

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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of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to implement their grievance policy to ensure a prompt resolution to resident grievances, failed to notify the residents of their right to file grievances orally and in writing, and failed to record and track grievances through to their conclusions. Additionally, the facility failed to ensure that all grievances contained the date and time the grievance was

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received, a summary statement of the grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, the date the written decision was issued to the resident and/or resident representative, and failed to ensure the resident/resident representative had the knowledge and access to file a grievance anonymously for three sampled residents (R10, R35, and R28). The deficient practice had the potential to affect all the residents in the facility. The facility reported a census of 44.

Findings include:

Review of the undated facility policy "Filing Grievances and/or Complaints" recorded it was the policy of the facility to assist residents, their representatives, other interested family members, or advocates in filing grievances or complaints when such requests are made. The policy further recorded that any resident, family member or representative could file a grievance and/or complaint regarding their medical care, treatment, behavior of other residents, staff members, theft of property, etc. without fear of threat or reprisal. Additionally, the policy recorded grievances must be submitted in writing and signed by the resident or the person filing the grievance, the Administrator was responsible for ensuring the allegations in the grievance were delegated to the responsible department in which the grievance had been filed, that the allegation was investigated and a written report was received within five working days of receiving the grievance and/or complaint, for ensuring the

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person who reported the grievance/complaint was notified of the findings of the investigation and the actions taken to correct the allegation, and lastly recorded it was the policy of the facility that the disposition of all grievances and/or complaints would be recorded on the facility "Grievance and Complaint Log". The policy lacked information that the resident/resident representative had the right to file a grievance/complaint anonymously.

Review of the undated facility policy "Grievances/Complaints-Staff Responsibility" recorded staff were encouraged to assist residents in filing a grievance and/or complaint when a resident believed their rights had been violated. The policy further recorded that should a staff member be the recipient of a complaint voiced by a resident or their representative the staff member would inform the resident/resident representative that they could file a grievance or complaint with the Administrator, and the staff member would inform the resident or resident representative that a grievance form could be obtained from the grievance/compliance officer. The policy lacked direction for how a resident/resident representative could file a grievance anonymously.

An observation on 4/8/24 at 2:30 PM showed on the bulletin board just inside the front door of the facility a posting that listed the Administrator as the Grievance Official for the facility and included an email and a telephone number under the Administrator's name.

Observations throughout the facility from 4/8-4/11/24 showed no postings regarding the resident/resident representatives right to file a grievance and/or complaint anonymously and

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revealed the lack of available grievance forms for residents and/or resident representatives.

Review of the 1/11/24 untimed "Resident Council and Dietary Council" meeting notes recorded the residents wanted staff reminded to pick up laundry every shift, especially if it was lying in the floor, to check on residents during the night, and to introduce new staff and temporary staff to the residents.

Review of the 2/8/24 at 10:00 AM "Resident Council and Dietary Council" meeting notes recorded the residents voiced concerns about staff not wearing their name tags, staff moving items in their rooms, requested less meatloaf be served and that all staff making meatloaf use the same recipe, and to please make sure the food on room trays was hot when served to the residents. The meeting notes lacked any follow-up information on the concerns the residents had verbalized during the January meeting.

Review of the 3/14/24 untimed "Resident Council and Dietary Council" meeting notes recorded the residents voiced concerns that meals were not being served on time, requested that coffee be offered to all residents even if they came late to the meal, and to offer coffee more than one time. The notes further recorded the residents would like for staff to be sure to assist visually impaired residents with knowing where their items were located. The meeting notes lacked any follow-up for the concerns the residents had verbalized in the February meeting.

1. Review of R10's 3/23/24 annual Minimum Data Set (MDS-a federally mandated assessment

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required to be completed by the facility) recorded the resident had a Brief Interview for Mental Status (BIMS) of 7 which indicated he was severely cognitively impaired. The MDS further recorded the resident had the following diagnoses, but not limited to, cerebralvascular accident (stroke), depression, and dementia and required assistance from staff for bathing, personal hygiene, dressing, toileting, bed mobility, and transfers.

During an interview on 4/9/24 at 12:54 PM, R10's family member indicated that the resident had a vest and jacket missing that he had purchased at the western store. The family member further indicated that he told the staff about the missing items and they [staff] said they would look for them but he did not know if they had been found.

Review of R10's medical record lacked a "Personal Property Inventory Sheet".

2. Record review R35's 2/26/24 quarterly MDS recorded the resident had a BIMS of 15 which indicated he was cognitively intact. The MDS further recorded the resident had the following diagnoses, but not limited to, traumatic brain injury (injury to the brain), personality disorder, depression, and retinal detachment of both eyes (serious eye condition that can result in loss of vision), and required the assistance of staff for ambulation with a walker, bathing, personal hygiene, dressing, and toileting.

Record review of R35's 12/4/23 annual MDS recorded the resident had a BIMS of 15 which indicated he was cognitively intact. The MDS further recorded the resident had the following diagnoses, but not limited to, traumatic brain

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injury, personality disorder, depression, and retinal detachment of both eyes, and required the assistance of staff for ambulation with a walker, bathing, personal hygiene, dressing, and toileting.

Review of R35's 11/29/23 comprehensive care plan recorded the resident had an activities of daily living (ADL's) self-performance deficit due to his impaired vision, impaired balance, and limited mobility. The care plan further recorded the resident had depression and a personality disorder, and the goal was that the resident would remain free of distress and symptoms of depression, anxiety, and sad mood. Interventions to be implemented by staff were recorded as monitor and report to physician increased anger, labile mood, or agitation and if he felt threatened by others.

During an interview on 4/8/24 at 4:02 PM, R35 indicated that staff were mean to him and would not tell him what their names were, and the "girl" yesterday tried to make him go to the dining room, and a couple of days ago he was talking on the phone to his bank and "the girl" tried to yank the phone out of his hand. R35 further indicated that he had an argument with his roommate over the trash can and the roommate grabbed his wrist but did not hurt him. R35 indicated that he reported the staff being mean to him and his roommate grabbing his wrist to the Social Services Designee (SSD) and "she just takes care of things". R35 indicated that he was not afraid of his roommate, and he felt safe in the facility, but he thinks the staff should treat him better. R35 further indicated that he did not know how to file a grievance and did not think anyone at the facility had talked to him about it, but he just told the Social Services Designee (SSD)

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when he had a complaint.

3. Record review of R28's 10/25/23 annual MDS recorded the resident had a BIMS of 15 which indicated that he was cognitively intact and had the following diagnoses, but not limited to, atrial fibrillation (irregular heartbeat), hypertension (HTN-high blood pressure), arthritis, and dorsalgia (chronic back pain). The MDS further recorded the resident required staff assistance with bathing, dressing, toileting, bed mobility, and transfers.

Record review of R28's 1/25/24 quarterly MDS recorded the resident had a BIMS of 15 which indicated that he was cognitively intact and had the following diagnoses, but not limited to, atrial fibrillation, HTN, arthritis, and dorsalgia. The MDS further recorded the resident required staff assistance with bathing, dressing, toileting, bed mobility, and transfers.

Record review of R28's 2/2/24 comprehensive care plan recorded the resident had a potential mood problem related to his health decline, nursing home admission, and his cognitive decline. The care plan further recorded the resident had mild depression, little interest, or pleasure in doing things, and had some recall deficits, and that he would ask if things had been done for his own benefit.

Review of R28's 1/29/24 at 4:17 PM "Progress Notes" recorded the resident called the SSD to his room and reported that over the weekend another resident had entered his room and took his lotion, and the nurse aide (NA) brought the lotion back to him. The note further recorded the SSD would check into what happened.

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Review of R28's 3/11/24 at 11:09 AM "Progress Notes" recorded that the SSD was called to the resident's room three times that morning and that the resident had called the SSD on the phone and requested she come to his room. The progress notes further recorded that the resident verbalized the resident in the room next door played his television too loud and it disturbed him. Additionally, the progress note recorded the SSD told the resident she would look into it and try to monitor so it didn't happen again.

Review of R28's 3/13/24 at 4:50 PM "Progress Notes" recorded the resident called the SSD to report that the man next door had his television up loud again today and was causing his blood pressure to go up. The progress notes further recorded the SSD checked with two other staff that did not feel the televisions on the hall were excessively loud but they [staff] did ask the residents to close their doors.

Review of R28's 3/13/24 at 5:16 PM recorded the resident complained again to the SSD that the man next door was causing his blood pressure to go up and the SSD looked at his recorded blood pressures and told R28 that his blood pressure was essentially the same for weeks before the man next door to him was admitted to the facility.

During an interview on 4/9/24 at 9:24 AM, R28 indicated that he frequently spoke with the SSD and facility administrator when he had complaints about care in the facility, other residents or staff, or a general concern. R28 indicated that he did not file a written grievance because he felt that the verbal complaint was sufficient. R28 further indicated that no staff ever offered to assist him

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with filing a written grievance and he was not sure if there were any grievance forms readily available. Additionally, the resident indicated that he was a lawyer, so he was aware of how to file a grievance, but he had not been informed about it [how to file a grievance] by the facility.

During an interview on 4/9/24 at 10:30 AM, the SSD indicated that she would talk to residents when they had complaints and "just try to fix" the issue but she did not write a grievance and just usually made a note in the resident's chart. The SSD further indicated that she did not think the facility had an actual grievance log.

During an interview on 4/10/24 at 8:15 AM, the Administrator indicated that she did not have any grievance logs for the surveyors to review as she had never had a grievance and therefore had no need for a grievance log and did not know that she needed to have a grievance log. The Administrator further indicated that when a resident had a complaint, they [facility staff] just handled it but they did not write anything down.

During an interview on 4/10/24 at 9:12 AM, the SSD indicated that she had transitioned from working in the laundry department to social services so residents would tell her if they were missing items. The SSD further indicated she was aware the resident used to have a black vest, but she was not aware it was missing but she would look into it. Additionally, the SSD indicated that she would write stuff down to remind herself to look for an item, but she would look for the item first and then if she could not find it, she would write it down to remind herself to keep looking.

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F 585	Continued From page 11 During a concurrent interview on 4/10/24 at 4:52 PM, the Administrator and Director of Nursing (DON) indicated that they did not have a specific "process" regarding lost items and if they [facility staff] could not find a missing item or if an item was damaged then they [facility] would replace the item but that they did not consider that a grievance.	F 585		
F 609 SS=J	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609	All policies regarding abuse were reviewed and will update as needed. All staff was educated on abuse and reporting on 04/08/2024. Interview was completed with R35 and he verbalized that he was safe to be at this facility and verbalized he is not injured. Education was completed to acknowledge any threat or potential threat of abuse of all residents. All Resident may be affected. Staff educated on need for immediate reporting of any abuse allegations. Education provider statin to report to supervisors and administrator immediately. Education was completed on 04/08/2024. Director of Nursing or designated staff will audit weekly for 4 weeks, then monthly for two months. Will take to QAPI for review and will be reviewed by Medical Director. Completion date: 04/08/2024 with ongoing audits	04/08/2024

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appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to identify a situation as alleged abuse, failed to immediately report the allegation to the administrator, and failed to report the allegation to the state survey agency (SSA) as required. The deficient practice had the potential to affect all the residents in the facility. The facility reported a census of 44.

The facility Administrator was notified of the IJ on 4/8/24 at 6:24 PM. The IJ was removed on 4/8/24 when the facility submitted and implemented an acceptable IJ removal plan on 4/8/24 at 8:35 PM. The S/S was lowered to a D following successful implementation of the removal plan.

The removal plan included:
Staff educated on need for immediate reporting of any abuse allegations.
Education provided stating to report to supervisor and administrator.
Education completed by 2035 (8:35 PM) on 4/8/24.

Findings include:

Record review R35's 2/26/24 quarterly Minimum Data Set (MDS-a federally mandated assessment required to be completed by the facility) recorded the resident had a Brief Interview for Mental Status (BIMS) of 15 which indicated he was cognitively intact. The MDS further recorded the resident had the following diagnoses, but not limited to, traumatic brain injury, personality disorder, depression, and retinal detachment of both eyes, and required the assistance of staff for

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AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

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ambulation with a walker, bathing, personal hygiene, dressing, and toileting.

Record review of R35's 12/4/23 annual MDS recorded the resident had a BIMS of 15 which indicated he was cognitively intact. The MDS further recorded the resident had the following diagnoses, but not limited to, traumatic brain injury, personality disorder, depression, and retinal detachment of both eyes, and required the assistance of staff for ambulation with a walker, bathing, personal hygiene, dressing, and toileting.

Review of R35's 11/29/23 comprehensive care plan recorded the resident had an activities of daily living (ADL's) self-performance deficit due to his impaired vision, impaired balance, and limited mobility. The care plan further recorded the resident had depression and personality disorder, and the goal was that the resident would remain free of distress and symptoms of depression, anxiety, and sad mood. Interventions to be implemented by staff were recorded as monitor and report to physician increased anger, labile mood, or agitation and if he felt threatened by others.

Record review of R35's 12/30/23 at 9:50 AM "Progress Notes" recorded resident reported that his roommate was trying to throw him out because he wouldn't allow the light on and that he felt threatened by his roommate. The progress notes further recorded that the DON and MDS Coordinator encouraged the resident to "give his roommate another chance" and the roommates were able to talk calmly and resolve the issue.

During an interview on 4/8/24 at 4:02 PM, R35 indicated that the staff were mean to him, would

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not tell him their name so he could not report them, and a couple of days ago he was on the phone talking to his bank and "the girl" tried to yank the phone out of his hand. The resident further reported that he did not know the staff names to report them, and he was essentially blind so he could not recognize them. Additionally, R35 reported that his roommate had grabbed his wrist when they were arguing over a trashcan. R35 stated he felt safe at the facility and was not afraid of his roommate but wanted staff to be nicer. R35 indicated that he had reported all information to the Social Services Designee (SSD), and she said she would take care of it.

During an interview on 4/8/24 at 4:15 PM with the SSD and Administrator, the SSD indicated that R35 told her he was upset with the nurse aide (NA) this morning because he felt like the NA treated him like a kid. The SSD then indicated that R35 was just upset and told her that he was tired of staff being abusive to him. The SSD indicated that she did not take the resident seriously when he said the staff was abusive to him and maybe she should have but she was just asking him how they were abusive, and he said that he heard the NA's give his roommate choices and he did not feel that he had been given the same choices.

During this concurrent interview, the Administrator indicated that the SSD had not informed her that the resident had indicated that staff were abusive to him and if they had she would have followed up on that information. The SSD then indicated that she would always try to talk to the resident and get him to calm down and she guessed she should have taken the situation more seriously.

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F 609	Continued From page 15 During an interview on 4/8/24 at 5:18 PM, the Director of Nursing (DON) indicated that the SSD never told her that the resident had reported abuse, but she has reported that the staff was biased or didn't give him time and she was told by the staff that the resident and his roommate had a verbal altercation, but SW never told her there was a physical altercation between the residents. The DON then stated "What if you don't believe the resident? Do you still have to do the investigation and report"? The DON confirmed she did not have an investigation pertaining to the verbal altercation between R35 and his roommate, but it occurred "around the end of December", and she had never been told about a physical altercation. Review of the 10/22/21 "Abuse and Neglect Policy and Procedure" revealed the facility was to have an effective system in place to ensure that all identified incidents of alleged abuse were promptly investigated and reported, to ensure that a complete review of events was documented, and all staff were responsible for reporting any situation that was considered abuse .....to notify the administrator immediately of alleged abuse ...to notify the designated agencies in accordance with state law, including the state survey and certification agency. The policy further recorded that if there was an incident of alleged abuse the physician would be notified and informed that there was an investigation in process. Additionally, the policy recorded that the SSD would report the results of all allegations to the state agency and other officials within five working days of the incident.	F 609		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation	F 610	All policies regarding investigations were reviewed and will update as	04/08/2024

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F 610	Continued From page 16 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to initiate an investigation of alleged abuse, failed to maintain documentation of the allegation of abuse, and failed to notify the facility Administrator of the alleged abuse for one sampled resident (R35). The deficient practice had the potential to affect all the residents in the facility. The facility reported a census of 44. The Administrator was notified of the IJ on 4/8/24 at 6:24 PM. The IJ was removed on 4/8/24 when the facility submitted and implemented an acceptable IJ removal plan on 4/8/24 at 8:35 PM. The S/S was lowered to a D following successful implementation of the removal plan. The removal plan included:	F 610	needed. All staff was educated on investigations on 04/08/2024. Investigations initiated by DNS, SSD, and Administrator. Staff education provided on Abuse policy and procedure given and verbalized to staff. Completed on 04/08/2024. Interview with R 35 completed and investigations completed and sent to the SD Department of Health for acceptance and notification. Resident does state that he is safe to be at this facility. All incidents for all residents will have investigation completed. All resident may be affected. Director of Nursing or designated staff will audit weekly for 4 weeks, then monthly for two months. Will take to QAPI for review and will be reviewed by Medical Director. Completion date: 04/08/2024 with ongoing audits	04/08/2024

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Investigation initiated by DNH, SSD, Admin.
Staff education provided on Abuse policy and procedures given and verbalized to staff 4/8/24 4:30 PM.
Immediacy completed by 8:35 PM.

Findings include:

Record review R35's 2/26/24 quarterly Minimum Data Set (MDS-a federally mandated assessment required to be completed by the facility) recorded the resident had a Brief Interview for Mental Status (BIMS) of 15 which indicated he was cognitively intact. The MDS further recorded the resident had the following diagnoses, but not limited to, traumatic brain injury, personality disorder, depression, and retinal detachment of both eyes, and required the assistance of staff for ambulation with a walker, bathing, personal hygiene, dressing, and toileting.

Record review of R35's 12/4/23 annual MDS recorded the resident had a BIMS of 15 which indicated he was cognitively intact. The MDS further recorded the resident had the following diagnoses, but not limited to, traumatic brain injury, personality disorder, depression, and retinal detachment of both eyes, and required the assistance of staff for ambulation with walker, bathing, personal hygiene, dressing, and toileting.

Review of R35's 11/29/23 comprehensive care plan recorded the resident had an Activities of daily living (ADL's) self-performance deficit due to his impaired vision, impaired balance, and limited mobility. The care plan further recorded the resident had depression and personality disorder, and the goal was that the resident would remain free of distress and symptoms of depression,

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anxiety, and sad mood. Interventions to be implemented by staff were recorded as monitor and report to physician increased anger, labile mood, or agitation and if he felt threatened by others.

Record review of R35's 12/30/23 at 9:50 AM "Progress Notes" recorded resident reported that his roommate was trying to throw him out because he wouldn't allow the light on and that he felt threatened by his roommate. The progress notes further recorded that the DON and MDS Coordinator encouraged the resident to "give his roommate another chance" and the roommates were able to talk calmly and resolve the issue.

During an interview on 4/8/24 at 4:02 PM, R35 indicated that the staff were mean to him, would not tell him their name so he could not report them, and a couple of days ago he was on the phone talking to his bank and "the girl" tried to yank the phone out of his hand. The resident further reported that he did not know the staff names to report them, and he was essentially blind so he could not recognize them. Additionally, R35 reported that his roommate had grabbed his wrist when they were arguing over a trashcan. R35 stated he felt safe at the facility and was not afraid of his roommate but wanted staff to be nicer. R35 indicated that he had reported all information to the Social Services Designee (SSD), and she said she would take care of it. R35 was unable to remember the date that his roommate had grabbed his wrist but thought it was "a couple of months ago".

During an interview on 4/8/24 at 4:15 PM with the SSD and Administrator, the SSD indicated that R35 told her he was upset with the nurse aide

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(NA) this morning because he felt like the NA treated him like a kid. The SSD then indicated that R35 was just upset and told her that he was tired of staff being abusive to him. The SSD indicated that she did not take the resident seriously when he said the staff was abusive to him and maybe she should have but she was just asking him how they were abusive, and he said that he heard the NA's give his roommate choices and he did not feel that he had been given the same choices. The SSD further indicated that she knew R35, and his roommate had several verbal altercations, but she did not recall that R35 told her about his roommate grabbing his wrist.

During this concurrent interview, the Administrator indicated that the SSD had not informed her that the resident had indicated that staff were abusive to him and if they had she would have followed up on that information. Additionally, the Administrator confirmed that she did not have any investigations documented regarding R35's complaints about altercations with his roommate or his treatment by staff. The SSD then indicated that she would always try to talk to the resident and get him to calm down and she guessed she should have taken the situation more seriously.

During an interview on 4/8/24 at 5:18 PM, the Director of Nursing (DON) indicated that the SSD never told her that the resident had reported abuse, but she has reported that the R35 thought the staff was biased or didn't give him time and she was told by the staff that the resident and his roommate had a verbal altercation, but SW never told her there was a physical altercation between the residents. The DON then stated "What if you don't believe the resident? Do you still have to do the investigation and report?" The DON

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F 610	Continued From page 20 confirmed she did not have an investigation pertaining to the verbal altercation between R35 and his roommate, but it occurred "around the end of December", and she had never been told about a physical altercation. During an interview on 4/8/24 at 6:00 PM, the DON indicated that she had initiated an investigation into R28's report of alleged abusive actions of staff but had not yet completed the investigation. Review of the 10/22/21 "Abuse and Neglect Policy and Procedure" revealed the facility was to have an effective system in place to ensure that all identified incidents of alleged abuse were promptly investigated and reported, to ensure that a complete review of events was documented, and all staff were responsible for reporting any situation that was considered abuse .....to notify the administrator immediately of alleged abuse ...to notify the designated agencies in accordance with state law, including the state survey and certification agency. The policy further recorded that if there was an incident of alleged abuse the physician would be notified and informed that there was an investigation in process. Additionally, the policy recorded that the SSD would report the results of all allegations to the state agency and other officials within five working days of the incident.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655	All policies regarding care planning were reviewed and will be updated as needed. Baseline care plans will be reviewed and added to the MAR to be completed within 48 hours of admission.	05/03/2024

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F 655	Continued From page 21 implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 655	Education was provided to nurses and SSD in regards to completing the baseline care plan process. Resident R140 family educated on deficient practice of giving them the ICP within the timeframe required. All new admissions with be audited for completion of this process. All other residents' charts will be audited and family notified if deficient practice found. All other residents may be affected. Audits on new admissions will be done weekly for four weeks and then monthly for two months. Will report audits to QAPI meetings and will be reviewed by Medical Director. Completion date: 05-03-2024	

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure the baseline care plan had been reviewed with the resident and/or the resident representative within 48 hours following admission to the facility for one of two residents (R) reviewed (R140) as a new admission. The facility reported a census of 44 residents.

Findings include:

The facility document titled "Care Plan Policy and Procedure" dated 8/8/23, stated all necessary resources and disciplines would be used to help ensure that residents achieve the highest level of functioning possible and maintain their sense of individuality. The facility would use the components of the RAI (Resident Assessment Instrument) including the Minimum Data Set, Care Assessment Tool, and Care Area Assessment (MDS, CAT, & CAA) to determine a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.
o Initial care plan would be initiated by the charge nurse on all admissions by filling out the interim care plan within the electronic health record.
o Social Services Designee (SSD) and the MDS coordinator would schedule care plan meetings within the CMS (Centers for Medicare and Medicaid Services) time allowance.
o Care conference attendance consists of an interdisciplinary team with a member from each department represented. Each department responsible for developing problems, goals, and approaches specific to their disciplines, utilizing

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the RAI.
o To help assist in care plan development with goals and time, residents and family members are encouraged to attend the care conference as their input is valuable and often vital.

The Minimum Data Set (MDS) assessment (a federally mandated comprehensive assessment) dated 3/27/24, for R140, identified date of admission to the facility 3/25/24. The MDS identified a Brief Interview of Mental Status (BIMS) score of 13, indicated no cognitive impairment. The MDS documented diagnoses that included: atrial fibrillation, heart failure, hypertension, neurogenic bladder, depression, and non-Alzheimer's dementia.

The Interim Care Plan (baseline care plan) for R140 dated 3/25/24, failed to include signatures and/or dates for the resident and/or resident representative and/or the staff completing the review with the resident and/or resident representative.

Record review lacked documentation that R140's baseline care plan had been reviewed with the resident and/or the resident representative 48 hours following admission to the facility.

On 4/9/24 at 9:36 AM, R140 in room resting on bed. R140 stated she had been in the facility for a couple of weeks after her caretaker had gotten sick and was no longer able to care for her at home. R140 stated she was hoping to return home with her caretaker. R140 stated she was not aware of the facility staff reviewing her plan of care with her following admission to the facility. The resident stated she did not recall the facility staff reviewing her care needs or the plan of care

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F 655	Continued From page 24 with her following admission to the facility. Interview on 4/9/24 at 3:40 PM, the SSD stated resident care conferences were completed according to MDS dates and would schedule the care conferences after notification from the MDS Coordinator and/or the Director of Nursing (DON). The SSD stated R140 would be due to for care conference since her admission MDS was completed. The SSD stated she was not aware of the need to review the baseline care plan with residents and/or family, that was not how she was trained. The SSD stated the DON had completed the interim care plan in the resident's medical record and maybe the DON would have reviewed with the resident and/or resident representative. The SSD stated she was not aware of the need to review the baseline care plan within 48 hours of admission with the resident and/or the resident representative. The SSD stated she would complete care conference with new admissions after their first MDS was completed, stated she believed she had 21 days to complete the care conference from the MDS assessment reference date. Interview on 4/9/24 at 3:47 PM, the DON stated she completed a 48-hour baseline care conference with R140's representative and not the resident. The DON stated she printed off the interim care plan and handed it to R140's representative and did not obtain signatures. The DON confirmed there was no documentation in the R140's clinical record that the baseline care plan was reviewed.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656	All policies regarding care planning were reviewed and will be updated as needed.	05/03/2024

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F 656	Continued From page 25 §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	Nurses, MDS Coordinator, Dietary Manager, Activities Director, and SSD will receive education on comprehensive care planning. R23 information regarding his AFO placed in the care plan and also orders. Information gathered from physician and family to use of AFO. Care plans of all residents will be audited for completed information. All residents may be affected. MDS coordinator or designee will audit ten percent of the care plans for completion until all care plans have been audited. MDS coordinator or designee will audit care plans weekly for four weeks and then monthly for two months. Will review at QAPI meetings and will be reviewed by Medical Director. Completion date: 05/03/2024.	

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requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, interview, and facility policy review, the facility failed to ensure a "Care Plan" was developed for the use of an AFO (Ankle Foot Orthosis/brace) for one (Resident (R) 23) out of one resident reviewed for assistive devices out of a sample of 18 residents. This had the potential for the AFO/brace to be applied incorrectly and/or not monitored causing adverse effects such as unnoticed skin issues.

Findings include:

Review of the facility policy titled, "Care Plan Policy and Procedure" with an update of 1/2/2020 and reviewed on 8/18/23 revealed, "All necessary resources and disciplines will be used to help ensure that residents achieve the highest level of functioning possible (quality of care) and maintain their sense of individuality (quality of life). 1. The initial care plan will be initiated by the Charge Nurse on all admissions by filling out the interim care plan within point click care during the admission process. Further assessments will be filled in on the remaining initial care plan by 48 hours by Department Managers. Comprehensive Care plan will be developed within seven days after the completion of the comprehensive assessment."

Review of the "Admission Record" located in the electronic medical record (EMR) under the

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"Admission" tab revealed R23 was admitted to the facility on 6/8/23.

Review of R23's quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an assessment reference date (ARD) of 3/9/24 revealed R23's "Brief Interview for Mental Status (BIMS)" score was a three out of 15 indicating the resident was severely cognitively impaired.

During an observation on 4/10/24 at 8:10 AM, R23 was in the dining room eating breakfast. The resident was noted with a brace to his left lower leg.

Review of R23's "Physical Therapy Evaluation and Plan of Treatment" provided by the facility with a certification period from 6/8/23 to 7/7/23 revealed the resident had a history of being kicked by a steer in the right ankle and his right leg was chronically bigger than the left. The family had noticed an increase drag of his left foot. There was no evidence in the evaluation that the resident had an AFO/brace.

Review of the second "Physical Therapy Evaluation" provided by the facility dated 7/7/23 completed after the resident returned from the hospital revealed no evidence the resident had an AFO/brace.

Review of R23's "Progress Note" located in the EMR under the "Progress Note" tab dated 3/9/24 (nine months after admission) revealed the resident did have a brace present to his left leg that was on during the day and off at night.

Review of R23's "Medication Administration

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Record (MAR)" and "Treatment Administration Record (TAR)" revealed no evidence of an order for the brace, when it was to be put on, taken off, or for the monitoring of the skin under the brace.

Review of R23's current "Care Plan" located in the EMR under the "Care Plan" tab revealed no evidence of a "Care Plan" related to the AFO/brace.

During an interview on 4/9/24 at 10:42 AM, Nursing Assistant (NA)2 confirmed R23 had a brace on his left lower leg. She revealed he had always had it and she puts the brace on in the morning when getting him ready for the day, and night shift takes it off before he goes to bed. She said she was not sure but thinks the brace was for stabilization.

During an interview on 4/9/24 at 3:10 PM, the Director of Nursing (DON) revealed R23 was admitted with the AFO/brace but was not exactly sure why he had it. She confirmed there was no "Care Plan" related to the use of the AFO/brace or a diagnosis for its use.

During an interview on 4/10/24 at 8:15 AM, NA4 confirmed R23 had a brace to his left leg and had it when he admitted last June 2023. She believed it was due to him dragging his left foot.

During an interview on 4/10/24 at 9:35 AM, NA3 confirmed she was assigned to the care of R23. She said she didn't know why the resident wore a brace. She said the resident told her to put in on him every morning when she got him ready for the day.

During an interview on 4/11/24 at 9:50 AM,

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F 656	Continued From page 29 Licensed Physical Therapy Assistant (LPTA) 1 revealed the Therapy Department did not give R23 the AFO/brace and she was not sure when he got the brace. She revealed she reviewed all his therapy notes and there was nothing regarding the AFO/brace. She revealed she would expect that there would be notes regarding the use of the AFO/brace.	F 656		
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 record review, observation, interview, and facility policy review, the facility failed to ensure a wound with staples and a wound with steri-strips had orders in place to assess and monitor the wounds and for dressing changes to the wounds for one (Resident (R)21) of one resident reviewed for non-pressure related skin issues out of a sample of 18 residents. This had the potential for the resident's wounds to worsen and possibly become infected. Findings include: Review of the facility policy titled, "Wound Assessment Policy and Procedure" with a review and revised date of 9/23 revealed, "All wounds	F 684	Administrator, DON, medical director, wound care consultant, and nurse designated responsible for resident skin assessments and care will review, revise and create as necessary the policies and procedures to ensure skin assessments occur timely, and appropriate per each resident's needs. Individual risk assessments for those with no risk identified, weekly skin assessments for those residents identified with risk, preventative measures care planned and routinely reviewed and identify interventions for those residents with skin integrity concerns performed by Director of Nursing or designee. All staff responsible for skin care will be reeducated on the updated policy and procedures for skin care.	5-3-2024

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F 684	Continued From page 30 will be evaluated weekly and whenever a change occurs in the wound . . . Non-Pressure wounds are to be documented on the Non-Pressure Skin Condition Report. Further details may be documented in the Nurses notes of the chart, which will be documented on each report sheet that a nurses note was made." Under "Specific Instructions" revealed, 1." Size: Use ruler to measure the longest and widest aspect of the wound surface in centimeters [cm] and record in millimeters [mm]; always measure length from head to toe. 2. Depth: Measure in cm and record in mm. 3. Edges . . . Attached - even or flush with wound base, no sides, or walls present, flat..... 6. Exudate Type and Amount: Bloody - thin bright red, serosanguineous - thin, watery, pale red to pink, Serous - thin, water, clear, Purulent - thin or thick, opaque tan to yellow, Foul purulent - thick, opaque yellow to green with offensive odor. Indicate, none - wound tissue dry, Scant - wound tissues moist, no measurable exudate, Small - wound tissues wet, moisture evenly distributed in wound; drainage involved less than 25% of dressing, Moderate - wound tissues saturated; drainage may or may not be evenly distribute in wound, drainage involved greater than 25% but less than 75%, Large - wound tissues bathed in fluid; drainage freely expressed; may or may not be evenly distributed in wound; drainage involved greater than 75% of dressing. 7. Skin color Surrounding Wound: Assess tissues within 4 cm of wound edge..... 13. Wound Status: Check previous assessment and indicate whether there is improvement, no change or whether the wound is deteriorating." Review of R21's "Admission Record" located in	F 684	All other residents will be re-assessed based on the updated policies and procedures to ensure that they have been identified as high risk or as having a skin condition and appropriate treatment and preventions are in place and being assessed per the updated policies and procedures. Order was received for R21 to have staples removed from his head and to allow steri-strips on his arms to fall off on their own. Director of Nursing or designee will audit all residents with skin conditions once per week for 4 weeks and once per month for two more months to ensure that the residents identified as high risk for skin conditions or those with skin conditions are receiving the appropriate care for treatment or prevention of skin conditions. Director of Nursing will present audit findings at the monthly QAPI meetings for review and consideration along with medical director. Completed 5-3-2024	

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electronic medical record (EMR) under the "Admission" tab revealed R21 was admitted to the facility on 1/31/24.

Review of R21's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 2/2/24 revealed R21's "Brief Interview for Mental Status (BIMS)" score was a 14 out of 15 indicating the resident was cognitively intact.

Review of the "Progress Notes" located in the EMR under the "Progress Notes" tab revealed on 4/6/23 at 11:25 PM, R21 was found in his room lying on the floor. The resident's forehead had a large skin tear on the right side. A very large pool of blood was under him. Two more lacerations were noted above his right ear. His physician was notified via fax. The next morning on 4/7/24 the Hospice nurse looked at his head and decided to send him to the Emergency Room (ER). He came back around noon and had staples in his head and steri-strips to his forearm.

Review of the Emergency Department (ED) report, untitled, located in the resident's hard chart, and dated 4/7/24, revealed the staples would need removed in seven days by either primary or with hospice care. Return if worsening symptoms or as needed. May use pain medicine as needed.

Review of R21's April 2024 "Medication Administration Record (MAR)" and "Treatment Administration Record (TAR)" revealed no evidence of any orders for the treatment to the resident's wound to his head with staples or his forearm with the steri-strips.

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During an interview on 4/9/24 at 2:00 PM, Registered Nurse (RN)1 confirmed there were no orders for the care of R21's wound to his head and stated that she just made sure the bandage was still on the wound and dry.

Review of the "Progress Notes," in the EMR under the "Progress Notes" tab revealed one progress note about the wound/bandage to the resident's head. Review of "Progress Note" dated 4/9/24 at 2:55 PM revealed "resident refused to let this nurse remove the dressing on his head to look at his staples/wounds on his head."

During an observation of R21 on 4/9/24 at 1:30 PM revealed the resident was in his recliner and said he did not want to answer any questions. The top of the resident's head was noted to be wrapped with kerlix and multiple bruises and scabs were noted to both arms.

During an interview on 4/10/24 at 10:00 AM, R21's Physician 1 revealed she was notified of the fall R21 had on 4/6/24. She further said she assumed the staples would be removed in seven to 10 days.

During an interview on 4/10/24 at 3:40 PM, the Director of Nursing (DON) confirmed there were no orders for the care of R21's staples to his head or the steri-strips to his forearm from the fall on 4/6/24. She further confirmed there was no appointment made for the removal of the staples. She confirmed there was no evidence of the assessment of the wounds in the medical record, such as how many staples, steri-strips, what the wound looked like, or any measurements of either wound.

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F 689 SS=K	Continued From page 33 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, policy review, and interview, the facility failed to have a process in place to mitigate a resident's risk for elopement for two of two residents (R) reviewed (R25 and R26). The facility failed to develop a comprehensive care plan with interventions in place to prevent elopements, complete a thorough investigation and/or review and revise interventions in place following an elopement and failed to notify the resident representatives and/or the providing physician regarding the resident's behaviors and/or elopement. The facility also failed to notify the required regulatory agency following an elopement from the facility. Specifically On 3/14/24, R25, identified with impaired cognition, a history of wandering, and exit seeking behavior exited door number nine by the beauty shop on the northeast end of the facility and went approximately 215 feet on uneven terrain and up an incline to the highway before staff were aware of the resident's location. R25's care plan failed to identify the resident at risk for elopement or interventions in place to prevent an elopement at the time the incident occurred. On 9/9/23 at 1:09	F 689	All policies regarding accidents/supervision/devices and wandering will be reviewed and updated as needed. Wandering risk scale is added to the standing orders. Will be put on the MAR to be completed on admission, after 72 hours, and one month. Care plans have been updated with interventions. This was completed on 04/10/2024. Interventions placed for residents R25 and R26 with place checks every 30 minutes for one week, then changed to hourly continually. All staff was educated on resident at risk of elopements, facility policy and procedures, and proper investigation on 04/10/2024. Director of Nursing or designated staff will audit 3 times a week for 4 weeks, then monthly for two months. Will take to QAPI for review and will be reviewed by Medical Director. Completion date: 04/10/2024 with ongoing audits.	04/10/2024

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AM, R25 exited the facility by the beauty shop twice and the facility staff found the resident outside and redirected her back inside the building.

The facility also failed to complete thorough investigations and/or root cause analyses to determine if supervision was adequate and interventions in place were adequate related to falls for two (R21 and R23) of two residents reviewed for falls. The facilities failures had the potential for additional elopements and falls to occur for all residents and potential for serious outcomes. The facility reported a census of 44 residents.

The facility Administrator was notified of the IJ (immediate jeopardy) on 4/10/24 at 5:24 PM. The Administrator was notified on 4/11/2024 at 10:55 AM of the ongoing IJ and steps expected for full removal. The S/S was lowered to an "E" following successful implementation of the removal plan. The Administrator was notified that the immediacy was removed on 4/11/2024 at 4:05 PM.

The removal plan included:
DON was educated by ____(name). On 4/11/24 at 1350 (1:50 PM) mountain time.
Care Plans have been updated and interventions implemented.
Staff has been educated on resident at risk of elopement, facility policy and procedures, and proper investigation.

Findings include:

The facility document titled, Elopement Policy revised 9/20/23, defined elopement by the National Institute for Elopement Prevention as

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when a resident who is cognitively, physically, mentally, emotionally, and/or chemically impaired wanders away, walks away, runs away, escapes, or otherwise leaves a caregiving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge.
o Review of the event with the department heads of nursing staff to assess, evaluate, and implement a plan for prevention of a following occurrence.
Prevention Measures:
o Missing person drills need to be conducted at least annually to help improve the effective response to any resident who is missing or wander away from the facility.
o Residents at risk for elopement would be assessed quarterly and as needed.
o Incident reporting policy and procedures would be followed for reporting, investigation, and QA monitoring.

The facility document titled Incident Reporting Policy and Procedure revised 10/31/13, stated incident reports would be completed by the staff member who witnesses or finds any incident (falls, impaired skin integrity, abuse and neglect, and medication errors) and given to the charge nurse on duty. After completion of the report forward to the Director of Nursing for final investigation. The initial report and investigation would be initiated at the time of discovery.
o Charge nurse would use the Nursing Facility Incident Report Flowsheet and Nursing Facility Reporting Tool for Abuse and Neglect Including Injury of Unknown Origin to assess for required regulatory agency reporting need, all state notifications must be reported within 24 hours of the incident unless serious bodily injury occurred these incidents must be reported within 2 hours.

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o Incidents that must be reported to the required regulatory agency, included elopement.
o The Director of Nursing would monitor incident reports and follow-up on investigations and report findings to the Quality Assurance Committee. Administrator would monitor all investigations and report findings to the Quality Assurance Committee. The Quality Assurance Committee would review need for changes in policies, procedures, or further preventative measures.

The facility document titled Resident Accident Prevention Policy and Procedures, 8/22/23, stated the policy of the facility was to ensure that the resident's environment remains as free as possible of accident hazards and that each resident receives adequate supervision and assistive devices to prevent accidents.
An accident was an unexpected, unintended event that can cause bodily injury. It does not include adverse outcomes associated as a direct consequence of treatment or care.
o The facility was continuously monitored by all staff for unsafe/hazardous conditions and corrections are promptly made as needed, to maintain a safe environment for residents.
o Door alarms were kept on and staff were trained to immediately respond when an alarm sounds to ensure that wandering residents were accounted for.
o All residents were assessed quarterly for their risk of the accidents and fall and received individualized care planning related to their individual needs.
o In an event and accident does occur, the appropriate incident report would be completed depending upon the incident.
o All reports reviewed by the Administrator and Director of Nursing.

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o Members of the interdisciplinary care plan team review of all incidents and make appropriate care planning changes if indicated.
o All reports reviewed at quarterly Safety Meetings and Quality Assurance meetings for number or pattern of accidents and corrective action.

The facility document titled Care Plan Policy and Procedure dated, 8/8/23 stated all necessary resources and disciplines would be used to help ensure that residents achieve the highest level of functioning possible and maintain their sense of individuality. The facility would use the components of the RAI (resident assessment instrument) including the Minimum Data Set assessment, Care Assessment Tool, and Care Area Assessment (MDS, CAT, & CAA) to determine a resident's functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.
o Initial care plan would be initiated by the charge nurse on all admissions by filling out the interim care plan within the electronic health record.
o Social worker and the MDS coordinator would schedule care plan meetings within the CMS (Centers for Medicare and Medicaid Services) time allowance.
o Care conference attendance consists of an interdisciplinary team with a member from each department represented. Each department responsible for developing problems, goals, and approaches specific to their disciplines, utilizing the RAI.
o To help assist in care plan development with goals and time, residents and family members are encouraged to attend the care conference as their input is valuable and often viral.

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o Care plans updated as needed and with quarterly care conferences.

1. The Minimum Data Set (MDS) assessment (a federally mandated comprehensive assessment) for R25 dated 8/18/23, identified a Brief Interview for Mental Status (BIMS) score of 6, indicated severely impaired cognition. The MDS identified the resident had disorganized thinking that fluctuated. The MDS revealed the resident required limited assist of one with transfers, ambulation, and locomotion on and off the unit. The MDS identified the resident was not steady with ambulation or turning around and only able to stabilize with staff assistance. The MDS indicated the resident used a walker with ambulation. The MDS documented diagnoses of hypertension, non-Alzheimer's dementia, senile degeneration of the brain, and history of falls.

The MDS assessment for R25 dated 11/18/23, identified a BIMS score of 3, indicated severely impaired cognition. The MDS identified the resident had inattention and disorganized thinking that fluctuated. The MDS revealed the resident required partial to moderate assistance with sit to stand and supervision or touching assistance when walking 10 feet, walking 50 feet with two turns, and walking 150 feet. transfers, ambulation, and locomotion on and off the unit. The MDS identified the resident was not steady with ambulation or turning around and only able to stabilize with staff assistance. The MDS indicated the resident used a walker with ambulation. The MDS documented diagnoses of hypertension, non-Alzheimer's dementia, senile degeneration of the brain, and history of falls.

The MDS assessment for R25 dated 2/18/24,

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identified a BIMS score of 11, indicated moderately impaired cognition. The MDS identified the resident had inattention and disorganized thinking that fluctuated. The MDS revealed the resident required partial to moderate assistance with sit to stand and supervision or touching assistance when walking 10 feet, walking 50 feet with two turns, and partial to moderate assistance walking 150 feet. transfers, ambulation, and locomotion on and off the unit. The MDS identified the resident was not steady with ambulation or turning around and only able to stabilize with staff assistance. The MDS indicated the resident used a walker with ambulation. The MDS documented diagnoses of hypertension, non-Alzheimer's dementia, and senile degeneration of the brain.

The Care Plan revised on 3/11/24, for R25, identified behaviors, however, failed to identify the resident's risk for elopement, wandering, and/or interventions in place in prevent an elopement.

The Wandering Risk Assessment for R25, dated 8/22/23, identified the resident at risk for wandering with a score of 9, due to: mobility, history of wandering, and diagnosis. The Wandering Risk Assessments dated 11/28/23 and 3/11/24, identified the resident at high risk for wandering with a score of 11, due to ambulation, diagnosis and wandered in the past month.

The facility document Resident Information List undated, located in a binder dated 8/31/23, identified R25 being on hospice, alert to self and confused, and independent with cares. Identified the resident had dementia, dry rough sense of humor, and gruff. Stated R25 would state she needed to get out of this damn place, loved

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candy, could have a beer a day, and refused medications at times.
The document lacked identification that R25 wandered, was exit seeking, history of elopement, and/or interventions in place to prevent an elopement.

The document titled POC (point of care) response history, for R25, with a print date of 4/11/24, identified behaviors in the last 30 days included:

a. 3/16/24 at 9:06 PM - wandering, yelling/screaming, abusive language, refuse care, cursing/screaming at others, and express frustration.

b. 3/17/24 at 7:54 PM - refuse care

c. 3/18/24 at 7:12 PM - yelling/screaming.

d. 3/26/24 at 9:59 PM - yelling/screaming, abusing language, grabbing others, express frustration, and screaming at others.

e. 3/29/24 at 10:44 AM - refuse care

f. 3/31/24 at 10:32 AM - cursing/screaming at others and express frustration.

g. 4/3/24 at 9:31 PM - cursing/screaming at others, express frustration, and threatening others.

h. 4/4/24 at 1:59 PM - refuse care

i. 4/4/24 at 9:01 PM - wandering, abusive language, and threatening behavior, physical aggressive towards others, cursing at others, express frustration, and threatening others.

j. 4/10/24 at 4:55 PM - abusive language, screaming at others, and threatening behavior.

The progress notes for R25 revealed:

a. On 9/9/23 at 1:09 AM, psychosocial note - the resident up ad lib in the hallway through the night. Early in the shift the resident went out the exterior door by the beauty shop twice. Staff were

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able to find the resident outside and redirected her inside the building.

b. On 9/14/23 at 5:35 PM, behavior note - the resident left the building using the front door. When the alarm went off, nurse responded and found the resident trying to go outside. The resident stated she wanted to go home. The resident did not want to return inside the facility. The resident had been wandering up and down the hallways, trying to push items around.

c. On 9/24/23 at 10:19 AM, behavior note - the resident wandering, stated looking for the bathroom and then stated she didn't need the bathroom, said she wanted to get out of there. The resident stated she wanted to go home.

d. On 9/24/24 at 2:55 PM, behavior note - the resident wandering around the building all shift, did not want to sit for long periods of time.

e. On 9/25/23 at 8:19 AM, health status note - notified hospice of resident's increased behaviors and exit seeking. The hospice team to discuss with the pharmacist and potentially increased the antipsychotic medication (work by altering the brain chemistry to help reduce psychotic symptoms).

f. On 9/25/23 at 3:15 PM, health status note - resident had increased behaviors, wandering, restlessness, and combative at times. Pharmacy and hospice recommend starting risperidone (antipsychotic medication) and stop the olanzapine (antipsychotic medication), family notified.

g. On 9/25/23 at 11:49 PM, health status note - the resident has been awake all shift, has not ambulated in hallway or exit seeking.

h. On 9/25/23 at 3:51 AM, behavior note - the resident continued to be awake in recliner.

i. On 9/26/23 at 11:08 AM, health status note - the resident had an increased in behaviors and

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not slept in 4 days. Family had been made aware of the medication changes and the insomnia. Hospice updated. Resident had been up and wandering in the hall early in the morning.

j. On 9/27/23 at 11:25 PM, behavior note - the resident ambulating into other resident rooms, pulling off covers and attempting to remove items.

k. On 1/6/24 at 11:21 PM, behavior note - the resident wandering in hallway, sat close to the nurse's station and provided a beer.

l. On 3/14/24 at 4:40 PM, behavior note - the resident exited the building and easily re-directed back inside. No injuries noted. The resident liked to wander in the facility daily.

m. On 3/16/24 at 1:55 PM, behavior note - the resident upset and walking around the facility hunched over. The resident stated she had to get out of here and go home. The resident given pretzels and a beer.

n. On 3/31/24 at 3:31 PM, behavior note - the resident refused toileting, changing clothes, and shower. The resident stated she needed to get out of the facility.

o. On 4/5/24 11:11 PM, behavior note - the resident wandering in and out of room.

The facility document titled Investigation on Injuries dated 3/15/24 at 10:00 AM, by the Administrator. Statement of occurrence: R25 had been walking around in the hallway when door alarm #9 sounded and the resident was outside of the building. The resident was easily redirected back into the facility. Spoke with the resident about going outside and educated her that she was able to go outside but may be safer to have staff assistance. The resident stated she did not know what she was doing and had episodes of not remembering. The resident does have times

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of crying and wondering the hallways, stating she wants to go home. Did not find any evidence of the resident knowingly exit seeking.

The facility document titled Elopement dated 4/11/24, identified R25 exited the facility on 3/14/24 at 4:40 PM.
Incident description: door #9 was alarming and NA5 (Nurse Aide) and NA8 responded to the door alarm, looked outside, and noted R25 outside walking with walker a few steps off the sidewalk in the grass. The resident stated she wanted to go home and get the hell out of there. NA1 reported that the resident made comments earlier that she wanted to go home. RN1 (Registered Nurse) reported she had been informed by the NAs of the resident exiting the facility.
Witnesses:
NA1 stated the resident had stated she wanted to go home earlier in the day. NA1 stated he heard the alarm sound but was with another resident and was unable to get to the alarm.
NA5 stated she heard the door alarming, noted it was door 9 opened, and immediately saw R25 walking with her walker. NA5 stated she approached the resident in the grass between the road and the sidewalk and easily re-directed back inside the facility.
RN1 stated she was doing cares with another resident and was unable to leave, stated she did not hear the alarms. RN1 stated R25 wanted to go home.
MDS Coordinator stated she was informed of the incident by NA8, that R25 had exited the facility through door 9 and was off the sidewalk in the grass, between the road and the sidewalk.
NA6 stated he heard the door alarming and was with another resident, unable to leave. NA6 stated he was informed of the incident after it was

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completed, and the resident was back inside.
Agencies/People Notified:
Physician and the Regulatory Agency on 4/11/24 at 9:36 AM and 9:38 AM respectively.

Note: The National Weather Service (www.weather.gov) recorded the temperatures for 3/14/24, maximum temperature 41 degrees (º) Fahrenheit (F), minimum temperature 21ºF, and the average temperature 31ºF. On 9/9/23, maximum temperature 74ºF, minimum temperature 54ºF, and the average temperature was 64ºF.

Observation on 4/9/24 at 8:55 AM, R25 in recliner, in room. R25 stated she had just gotten up and not had breakfast. R25 ambulated independently without assistive device towards the dining room. The facility staff approached the resident and ambulated to the dining room.

Observation on 4/9/24 at 5:00 PM, R25 in the nurses station with facility staff reading through her medical record.

Observation on 4/10/24 at 3:30 PM, R25 tearful as she ambulated down the hall without an assistive device, linked arms with the facility staff.

Observation on 4/11/24 at 9:55 AM, R25 in the Administrator's office, tearful, and the Administrator talking with the resident.

Observation on 4/11/24 at 3:45 PM, from the facility exit door #9, by the beauty shop, the sidewalk to the grassy area was 15 feet and then from the grassy area to the incline by the highway was 215 feet. R25 would have ambulated at least 230 feet on an uneven grassy terrain and up an

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incline to the highway before staff found the resident.

Interview on 4/9/24 at 2:08 PM, NA4 stated she had worked at the facility for seven years. NA4 stated she was not aware of a list of residents that wandered, stated our residents were good and did not wander or elope. NA4 stated if she observed residents acting weird, she would notify the nurse. Stated she would watch residents' behaviors, as she knew how they acted and if their behaviors were off, she would notify the nurse. NA4 stated there was a panel at the nurse's station to alert you which door alarm was sounding and once you responded to the door, turn off the alarm and go outside to make sure there were no residents outside. If no residents located outside, she would check to make sure all residents were accounted for. NA4 stated she was not aware of R25 exiting seeking or setting of any door alarms.

Interview on 4/9/24 at 2:23 PM, RN2 (Registered Nurse) stated she was aware of R25 wandering; however, the resident did not exit seek. RN2 stated there were other residents who would wander but didn't attempt to leave the facility. RN2 stated there were no resident's that purposefully tried to exit the facility. RN2 stated the panel at the nurse's station who alert to the exit door that had been activated and when respond to the appropriate door. If there were no residents observed would search to see who had gone outside and complete a resident head count. RN2 stated there were times the wind would open the exit doors and cause the alarms to sound.

Interview on 4/9/24 at 3:01 PM, NA9 stated she

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worked at the facility for agency for approximately 6 months. NA9 stated when she started at the facility, she had been informed verbally of residents that wandered and/or would exit seek. NA9 stated R25 would walk up and down the halls but doesn't wander and she does not attempt to leave the facility. NA9 stated would respond to a door alarm, generally the front door and then check to see of a resident went outside. NA9 stated if she does not see a resident, would tell the nurse and then complete head count of all the residents.

Interview on 4/9/24 at 3:51 PM, the Director of Nursing (DON) stated there were residents that wandered, however, there were no residents that were an elopement risk. The DON stated there were currently no residents that actively elope. The DON stated R25 would exit seek and was confused at times. The DON stated R25 would get to an exit door and stopped. The DON confirmed R25's care plan did not include wandering and/or elopement risk. The DON stated if a resident was at risk for wandering and/or elopement would expect it to be on the resident's care plan. The DON stated there were detailed report sheets in a binder at the nurse's station for all staff that included details about each resident including high fall risk, pressure ulcer, diabetics, code status, and physicians. The DON stated new staff to the facility were provided a report sheet and there were copies in the drawer at the nurse's station for all staff. The DON stated the NAs gave daily verbal report to each other and changes would also be documented on a daily clipboard. The DON stated with the incident on 3/14/24, she was sure the door alarm went off and guessed the facility staff saw R25 on the sidewalk. The DON stated

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RN1 was the nurse on duty at the time.

Interview on 4/10/24 at 8:24 AM, RN1 stated she worked for agency and had been in a resident room at the time of R25's incident on 3/14/24. RN1 stated she had been informed later, however, stated the DON knew about the incident. RN1 stated she thought the facility staff responded to door alarm, the NAs went out to get R25, and brought her back in. RN1 stated she didn't think R25 had made it very far out the door. RN1 stated when she was told later about the incident, she charted what she had been told. RN1 stated R25 did not want to be at the facility and had a lot of anxiety. RN1 stated R25 was admitted to hospice, had scheduled anxiety medication due to outbursts, and being uncooperative. RN1 stated R25 did not take her medications like she was supposed to. RN1 stated R25 would tell staff she was going to leave the facility all the time. RN1 stated the incident on 3/14/24, was the only time R25 had eloped from the facility while she was working. RN1 stated R25 wanders a lot, and the hospice staff would take her outside for a walk, weather permitting, and she would return inside without a problem. RN1 stated R25 did not want to be at the facility.

Interview on 4/10/24 at 8:38 AM, the Administrator stated the only investigation she had for R25 was the typed summary of events titled Investigation on Injuries dated 3/14/24. The Administrator stated she spoke with resident about going outside on 3/15/24 and confirmed there were no employee statements and/or interviews from the incident.

Interview on 4/10/24 at 9:19 AM, the Social Service Designee (SSD) stated R25 walked the

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halls frequently and sat at the desk at the nurse's station. The SSD stated R25 was able to find her way to her room and the dining room herself and that she did not like to use walker and staff will walk with her. The SSD stated R25 did not go into other resident rooms, so she did not think the resident was wandering. The SSD stated R25 would walk the halls frequently and felt it is because R25 did not want to be in her room. The SSD stated when it was nice outside, hospice would take R25 outside for walks. The SSD stated R25 would mainly walk the hall where her room was and had not witnessed R25 exit seeking. The SSD stated she knew it was documented in R25's record that she had exited the facility, however, stated did not know about the incident until it was brought to her attention on 4/9/24. The SSD stated R25 would go in staff offices to visit, she does recognize staff and has her favorites. The SSD stated R25 was upset the previous day and was sat with her chart in nurse's station. The SSD stated if she knows R25 is upset she would take her to the SSD office for a one to one. The SSD stated the Administrator would take R25 into her office as well. The SSD stated there were times the nurses would take her in the nurse's station if she was upset to sit with them and there were times R25 would only want to be with certain staff for the one to ones. The SSD stated she was sure she didn't even mark it as a one to one and should do more documenting.

Interview on 4/10/24 at 9:56 AM, the Activities Director (AD) stated R25 enjoyed reading the mass bulletin, however, would leave the area when bingo started. The AD stated R25 would attend entertainment, coffee, and snack, and looking out the windows, however, would stay in

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room a lot. The AD states there were times R25 did not want to talk to anyone. The AD stated she was not aware of R25 exit seeking, stated she had not witnessed the resident exit seeking. The AD stated she did not consider R25 walking the halls wandering because she did not go into other resident room. The AD stated R25 would sit at the desk at the nurse's station, especially when her roommate had visitors. The AD stated she was not aware of a list of residents that wander. The AD stated she was not aware R25 had been out of the facility in March, not aware of the alarm going off or the resident being outside. The AD stated she had difficulty hearing the door alarms in the activity area by the front door.

Interview on 4/10/24 at 1:16 PM, H1 (Housekeeping) stated the housekeepers were the bartenders of the facility, heard about all that went on and everyone's problems. H1 stated she was not aware of R25 exiting the facility or her attempts to exit the facility. H1 stated R25 did not like to be in her room with her roommate and would walk around throughout the facility. H1 stated she was not aware of a list of residents who wandered and/or at risk to exit the facility. H1 stated all staff were informed in the 2:15 stand up daily meeting of any identified issues. H1 stated she was not aware of any other residents exit seeking or exiting the facility.

Interview on 4/10/24 at 2:39 PM, NA7 stated she was no longer employed at the facility and had only worked at the facility for a few weeks. NA7 confirmed she had worked on 3/14/24 and was orientating with NA8. NA7 stated she heard the door alarm sound and by the time she responded to exit door #9 with NA8, R25 was going up the incline towards the highway in front of the facility.

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NA7 stated R25 informed the staff she was heading out. NA7 stated R25 had her walker, an extra pair of shoes and a snack. NA7 stated R25 was easily re-directed back into the facility. NA7 stated she was not provided a list regarding residents that were wanderers and/or an elopement risk when she started at the facility. NA7 stated she had been provided a list that included residents transfer information, however, it was an old list and NA8 had to add and/or cross residents off. NA7 stated she was not aware of any resident's that wandered and/or attempted to leave facility except for R26.

Interview on 4/10/24 at 3:04 PM, NA5 stated she worked at the facility through agency and confirmed she had worked at the facility on 3/14/24. NA5 stated she did not recall R25 sounding the alarm and/or exiting the facility on 3/14/24. NA5 stated she was not aware of R25 exit seeking behavior and that the incident on 3/14/24, was the only occurrence. NA5 stated she was not aware of any residents exiting the facility unattended.

Interview on 4/10/24 at 3:10 PM, NA6 stated he worked at the facility through agency and had recently finished his contract and had worked at the facility for close to a year. NA6 confirmed he had worked at the facility on 3/14/24, however, did not recall R25 exiting the facility. NA6 stated he had been trained on the door alarms and was provided a report sheet with resident information; however, he was unsure if the report sheet identified the residents that wandered. NA6 stated he was not aware of any residents getting outside the facility while working his contract.

In an interview on 4/10/24 at 5:02 PM with the

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DON and the Administrator, the DON stated the SSD would complete the MDS sections on mood and behavior and would include on the care plans as needed. The DON stated the MDS Coordinator and herself would confirm that identified areas of concern would be included on the care plans due to the SSD being in her role for less than a year. The DON stated she had not completed an investigation for R25 eloping from the facility on 3/14/24, as she did not feel that resident had eloped from the facility. The DON stated resident sounded the door alarm and did not get off the facility property. The DON stated any resident could go outside of the facility without staff knowledge and not within staff sight. and are always not in staff sight. The DON confirmed the facility had residents that were cognitively impaired. The DON stated she expected staff to be aware of the interventions to prevent elopement and the interventions be included on the care plan. The DON stated she would have to review the facilities risk management to determine if there was additional information or an investigation related to the incident on 3/14/2, however, continued to state that she was sure there would not be any additional information because she did not consider R25's elopement an elopement. The DON stated the R25 was on the sidewalk and easily re-directed right back in the facility. The DON stated she had not been informed R25 had made it to the road and that R25 would not be able to get to the road with her walker. The DON stated she had interviewed all the staff working the night of 3/14/24, however, did not document the interviews that were completed and did not report the elopement to the required regulatory agency, as did not feel it was an elopement. The DON proceeded to say R25 needed a locked unit

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as the facility could not prevent her from getting outside. The DON and the Administrator stated the facility had a consulting/management company; however, they were more for financials and business office assistant that there was no nurse consultant. The DON stated when the facility would ask about nursing related questions, they were informed to call another facility that utilized the same management company because the other facility had a good system in place. The Administrator and DON confirmed there was no investigation into R25's documented elopement and they failed to report the elopement to the state agency.

Interview on 4/11/24 at 8:55 AM, the Administrator stated she would follow the policy and reporting guidelines related to R25's elopement, however, did not realize she needed to report it since it was so far back but would now. The Administrator stated the DON was working on the investigation but has just started working on it as she did not understand she needed to start it last night.

Interview on 4/11/24 at 9:50 AM, the DON stated she had completed the investigation and provided a copy related to the elopement of R25 on 3/14/24 and submitted to the incident to the required regulatory agency. The DON proceeded to state she did not understand why she had to complete the investigation when the R25 did not elope from the facility. The DON stated she completed the investigation because she had been informed by the RO surveyors that it was required. The DON continued to state the door alarms sounded, staff responded, and found the resident on the sidewalk.

Interview on 4/11/24 at 10:57 AM, the

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Administrator was notified that the IJ for F689 was ongoing as the DON did not have a clear understanding of the elopement and still felt that the facility should not have had to report or investigate the elopement. The Administrator stated she was reaching out to the QIO (Quality Improvement Organization) and would have the DON educated on rights and responsibilities related to her action (inaction). The Administrator did not understand that she was to follow all necessary steps for reporting elopement because the RO surveyors notified her of the elopement, so she did not think she had to report. The Administrator verbalized understanding and was working on abatement of the tag F689.

During an interview on 4/11/24 at 4:05 PM the Administrator indicated that she was not aware that R25 had eloped from the facility on 3/14/24. The Administrator further indicated that the elopement occurred on a weekend, she was out of town and did not have a cell phone signal and when she returned to work the following Monday, she was not informed by the DON that R25 had eloped. Additionally, the Administrator indicated that she was unaware of the elopement until the surveyor notified her of it.

2. The MDS assessment for R26 dated 1/13/24, identified a BIMS score of 12, indicated moderately impaired cognition. The MDS identified the resident wandered daily and the wandering placed the resident at significant risk of getting to a potentially dangerous place (e.g. stairs, outside of the facility). The MDS indicated the wandering was worse than previous assessment. The MDS coded the resident for use of walker and wheelchair. The MDS revealed the resident required partial to moderate assistance

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with sit to stand and supervision or touching assistance when walking 10 feet and walking 50 feet with two turns. The MDS documented diagnoses of hypertension, non-Alzheimer's dementia, anxiety, and altered mental status.

The Care Area Assessment (CAA) Summary identified R26 triggered for behavioral symptoms and triggered area was addressed in the care plan.

The CAA worksheet for R26 dated 1/15/24, identified triggering conditions of wandering and change in behavior. The CAA stated the resident tooled around in his wheelchair for independent mobility. R26 had tried to exit seek and left the building in his wheelchair, staff responded to the door alarm and the resident did not get all the way outside. The weather was below 0 and this did not stop the resident from trying to go outside. Seriousness of the behavioral symptom, resident was an immediate threat to self. Cognitive status: delirium, a serious change in mental abilities that results in confused thinking and a lack of awareness of surroundings. R26 does not always show signs of delirium but does when he tries to leave the building in below 0 temperatures.

The Care Plan for R26 dated 1/11/24, identified focus areas of impaired cognition related to dementia and mood problem related to anxiety. R26's care plan failed to identify the resident's risk for elopement, wandering, and/or interventions in place to prevent an elopement.

The facility document titled Resident Information List, undated, located in a binder dated 8/31/23, documented R26 alert and orientated x 2-3, confused, pleasant, and wandered in wheelchair.

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The documented stated the resident loved hot chocolate, required extensive assist of one, had chronic migraines and loved a cold compress to his head, and enjoyed reading his bible and eating candy.

The Care Conference Note dated 1/30/24, attended by the MDS Coordinator, therapy, Dietary manager, and the daughter via phone identified behavior of exit seeking.

The Progress Notes for R26 revealed:

a. On 1/11/24 at 2:39 PM, admission summary - the resident transferred from the hospital, had previously been in a memory care unit.

b. On 1/12/24 at 3:01 AM, health status note - the resident was restless and wandering in hallways. The resident was agitated with instruction at times.

c. On 1/19/24 at 3:11 AM, health status note - the resident seemed restless and requested medications often. The resident wandered in the hallways, easily redirected.

d. On 1/24/24 at 1:20 PM, behavior note - responded to the door alarm and found the resident with the door open, assisted the resident to close the door. The resident provided with paper and pen as requested to write a letter.

e. On 1/31/24 at 4:49 AM, health status note - the resident was wandering around at 11 PM requesting snacks.

f. On 2/1/24 at 2:50 AM, health status note - the resident wandered in the hallway and was easily redirected.

g. On 2/2/24 at 3:26 AM, health status note - the resident wandered in the hallway and provided snack as requested.

h. On 2/6/24 at 1:17 AM, health status note -

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the resident wandered in the hallway and was easily redirected.

i. On 2/10/24 1:03 AM, health status note - the resident continues to wander the halls at night.

j. On 3/20/24 at 1:40 AM, behavior note - the resident wandering in the halls last night and tonight, requests snacks and writes letters.

k. On 4/4/24 10:03 AM, behavior note - the resident wandering into other resident rooms and going through roommates' belongings.

l. On 4/7/24 at 5:44 AM, health status note - the resident wandering in the halls during the night.

Interview on 4/9/24 at 2:08 PM, NA4 stated she was not aware of R26's wandering and exiting seeking behavior. NA4 stated she was not aware R26 setting off the door alarm attempting to exit the facility.

Interview on 4/9/24 at 2:23 PM, RN2 stated R26 wanders throughout the facility and had opened the door, setting off the alarms, but never went outside the facility.

Interview on 4/9/24 at 3:01 PM, NA9 stated R26 attempted to exit the facility one time, tried to leave, however, does not do it anymore. NA9 stated R26 does go into others resident rooms to steal snacks.

Interview on 4/9/24 at 3:51 PM, the DON stated R26 would set off the alarm at the front door when first admitted to the facility, however, did not exit the facility. The DON stated R26 has never gotten outside of the facility, it was cold out and believed he would have turned around and came back inside. The DON stated R26 was previously

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in a locked unit at an assisted living facility. The DON confirmed R26's care plan did not include wandering and/or elopement risk. The DON stated R26's care plan did have a focus area for wandering and/or elopement dated 4/9/24, however, no interventions included. The DON stated she believed the MDS Coordinator was just starting on the elopement care plan area. The DON stated she expected wandering and elopement risk for be on R26's care plan.

Interview on 4/10/24 at 1:16 PM, H1 stated not too long after R26 was admitted to the facility he would attempt to exit the building. H1 stated all staff were on high alert when the door alarm sounded and would check to see which door alarm was activated and respond to the door. H1 stated at one time she was cleaning by the beauty shop and R26 was attempting to exit the through the door by the beauty shop. H1 stated R26 did tend to wander into the west hall after lunch and that was the hall cleaned after lunch so the housekeepers would attempt to re-direct him.

Interview on 4/10/24 at 9:07 AM, confirmed the SSD had documented R26's electronic health record (EHR) on 1/24/24 when the resident attempted to exit the facility activating the door alarm. The SSD stated R26 was holding the door open when she responded to the alarm, on 1/24/24, and that the resident did not cross the threshold. The SSD stated it was chilly outside and the resident changed his mind so to speak. The SSD stated she did not recall which door the resident was at, probably not the front door because that goes into a vestibule area and not directly outside. The SSD stated R26 easily returned inside, and she did not recall if reported the incident to the charge nurse. The SSD stated

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the facility had a 2:15 PM daily meeting when staff got together for updates to make sure everyone was aware of what was going on, refresher course. The SSD stated R26 does continue to wander throughout the facility and there are times he goes out to the dining room looking for a table to write. The SSD stated R26 usually goes down the west hall, does not see him go past his room to the east hall. The SSD stated she had not seen R26 exit seek since the incident on 1/24/24, however, stated she wouldn't say he wouldn't do it again as he does frequently say he wants to go to AZ.

Interview on 4/10/24 at 9:52 AM, the AD stated R26 enjoyed participating in morning activities, bingo, afternoon activities, reading books, and writing with paper and pens. The AD stated at times she would stop in to visit with R26, however, he would have a washcloth on head and hard to get him to visit. R26 does enjoy reading his bible. The AD stated R26 did like to look out windows and doors in the activity room. The AD stated she had not seen R26 exit seek since he first came into the facility, however, a few days ago came he attempting to open the front door and the alarm sounded causing the resident to back away.

Review of the facility's policy titled, "Fall Management Policy and Procedure" with an update of 8/22/23 revealed, Purpose: "To follow up appropriately if a fall occurs. Definition of a Fall: A fall is defined as a sudden, uncontrolled, unintentional, downward displacement of the body to the ground or other object. A near fall is a sudden loss of balance that does not result in a fall or other injury. This can include a person who slips, stumbles or trips that does not result in a fall or other injury. This can include a person who

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slips, stumbles or trips, but is able to regain control prior to falling. An un-witnessed fall occurs when a resident is found on the floor and neither the resident nor anyone else knows how he or she got there."

Under the "Nursing Procedure after a Resident Fall"..... 5. "Evaluate resident and environment for future prevention. 6. Complete risk assessment on PCC [point click care]..... 9. Reinforce identified risks with resident/family/nursing staff..... 11. Update the Comprehensive Care Plan with any changes or new interventions."

Under the "Resident Accident prevention Policy and Procedures".....7. "All residents are assessed quarterly for their risk of accidents and falls and receive individualized care planning related to their individual needs. 8. In the event an accident does occur, the appropriate incident report is completed depending upon the incident. 9. All reports are reviewed by Administration and the Director of Nursing. 10. Members of the Interdisciplinary Care Plan team review all incidents and make appropriate care planning changes if indicated."

Review of the facility policy titled, "Incident Reporting Policy & Procedure" revised 10/31/13 revealed, "Incident reports will be completed by the staff member who witnesses or finds any incident (falls, impaired skin integrity, abuse and neglect, medication errors) and given to the Chare Nurse on Duty. After completion, the report will be forwarded to the Director of Nursing for final investigation. The initial report and investigation will be initiated at the time of discovery."

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3. Review of R21's "Admission Record" located in electronic medical record (EMR) under the "Admission" tab revealed R21 was admitted to the facility on 1/31/24 with diagnoses of atrial fibrillation (irregular heartbeat) and fatigue.

Review of R21's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 2/2/24 revealed R21's "Brief Interview for Mental Status (BIMS)" score was a 14 out of 15 indicating the resident was cognitively intact. R21's mobility status was independent with the use of a wheelchair or walker.

Review of the "Morse Fall Scale" located in the EMR under the "Assessments" tab dated 1/31/24 revealed R21 scored a 65 with a score over 45 indicating a high risk for falls. "Fall Risk is based upon Fall Risk Factors and it is more than a total score. Determine fall risk factors and target interventions to reduce risks."

Review of R21's "Care Plan" located in the EMR under the "Care Plan" tab with a revision date of 3/14/24 revealed the resident was a high risk for fall related to gait, balance problems, weakness, and history of numerous falls at home. Interventions included to ensure his call light was in reach, ensuring proper footwear, a safe environment with even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light, the bed in low position at night, personal items at reach and to follow the facility's fall protocol.

Review of R21's "Progress Notes" located in the EMR under the "Progress Notes" tab revealed the

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following falls since admission:

On 2/5/24 at 1:45 PM, R21 walked in the Director of Nursing's [DON's] office to visit. R21 fell backwards as he missed the chair he was going to sit in and landed on his buttocks and hit his head against the heater on the wall. It was noted R21 had two scratches to the top of his head measuring 1.5 centimeters (cm) by 0.1 cm, a skin tear to the left hand and a small hematoma.

On 2/6/24 at 4:05 AM, R21 was found lying on the floor beside his bed. He was assisted by two persons to his recliner. There was no evidence of any other documentation of an assessment for any injuries at the time of the fall. On 2/7/24 it was noted the resident had bruising to his mid/lower back from the fall and bruising to bilateral arms, he denied any pain.

Review of the "Morse Fall Scale" located in the EMR under the "Assessments" tab dated 03/22/24 revealed R21 now had a fall risk score of 80, indicating the resident was a high risk for falls. Review of the "Care Plan Care Plan" located in the EMR under the "Care Plan" tab with a revision date of 3/14/24 revealed no new interventions despite the increased fall risk score.

Continued review of R21's "Progress Notes" located in the EMR under the "Progress Notes" tab revealed the following additional falls:

On 3/23/24 at 11:06 PM, R21 was sitting at the nurse's desk and he had tied his jacket over his lap on the chair arms and he tried to get up and fell backwards in the chair and hit his arm. He was noted with an 8 cm x 2 cm skin tear. A dressing was applied to cover the wound.

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AURORA BRULE NURSING HOME INC	408 SOUTH JOHNSTON STREET WHITE LAKE, SD 57383

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On 3/24/24 at 9:40 PM, a Certified Nursing Assistant (CNA) was outside R21's room and heard a bang. When entering the room, the resident was on the floor by the closet door and there was a huge amount of blood on the floor. The only injury noted was a nodule on his left elbow was open and bloody. The area was covered with a dressing. It was noted the resident had shoes on and said he went backwards and slid down the door. He was assisted to his recliner and his daughter was notified. On 3/25/24 it was noted the resident had an open area to his shoulder from the fall. No other documentation from the injuries were noted.

On 4/6/23 at 11:25 PM, a CNA had heard R21 calling out and when she went to check on the resident he was lying on the floor under the window. The resident's forehead had a large skin tear on the right side. A very large pool of blood was under him. "We cleaned up quite a bit of blood and then assisted him to stand and helped him to walk to his recliner." Two more lacerations were noted above his right ear. He had shoes on and his call light was hooked on his recliner. "The resident said he was walking and he just fell down against the dresser." His walker was by the bathroom door. His family was notified via text and telephone. His physician was notified via fax. On 4/7/24 the Hospice nurse looked at his head and decided to send him to the emergency room (ER). He came back around noon and had staples in his head and steri-strips to his forearm.

During an observation of R21 on 4/9/24 at 1:30 PM, it was revealed the resident was in his recliner and said he did not want to answer any questions. The top of the resident's head was

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noted to be wrapped with kerlix and multiple bruises and scabs were noted to both arms.

A request was made on 4/9/24 at 2:00 PM to the Administrator for all investigations for all R21's incidents. One hand-written investigation was received for the fall of 4/6/24 and was dated 4/10/24 (four days after the fall). No other investigations were received prior to the exit of the survey.

Review of the "Investigation on Injuries" report provided by the facility and completed by the Administrator dated 4/10/24 revealed the date of the incident was 4/6/24 at 11:25 PM. The investigation revealed on 4/7/24 at 9:00 AM the Hospice nurse was in the facility to assess R21's injury from his fall on 4/6/24 and determined he should go to the ER to evaluate the laceration on his head. At noon, the resident returned from the ER with staples placed in his head. The resident was interviewed on 4/8/24 at 10:00 AM and said he didn't really remember too much but knew he fell. On 4/8/24 at 6:30 PM, the nurse who was working at the time of the resident's fall was interviewed and revealed the resident was in his room, and she was contacted by the CNA and when she entered the room he was lying on the floor with a large amount of blood present. The resident was alert and assisted by two staff to his recliner. Bleeding was controlled with Telfa and Kerlix. The resident denied pain anywhere other than his head. A large skin tear on the right side of his forehead with a laceration was noted, as well as a couple other small skin tears by the resident's right ear. Neuro and vitals competed. At 8:00 PM on 4/8/24, the CNA was interviewed who found the resident and stated she was doing hourly checks on the resident due to him being

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agitated earlier in the evening and at 11:00 PM the resident was in his chair resting. Then when going down the hallway to check another resident when she walked by his room and heard moaning and grunting. She entered the resident's room and he was lying on the floor and a large amount of blood was by him. She contacted the nurse and they helped him to the recliner. The CNA stated that the resident had told her that he was trying to go to the bathroom and his walker got caught on the nightstand and he tripped. His walker was over the top of him and she moved it into the bathroom. The resident's family was notified.

3. Review of the "Admission Record" located in the EMR under the "Admission" tab revealed R23 was admitted to the facility on 6/8/23 with diagnoses of dementia and repeated falls.

Review of R23's quarterly "MDS" located in the EMR under the "MDS" tab with an ARD of 3/9/24 revealed R23's "BIMS" score was a three out of 15 indicating the resident was severely cognitively impaired. R23's mobility status included the use of a wheelchair independently and a walker with moderate assistance. The "MDS" further revealed the resident had two falls since the last assessment.

Review of R23's "Care Plan" located in the EMR under the "Care Plan" tab with a revision date of 3/3/24 revealed the resident was at risk for falls related to confusion, gait, and balance problems. Interventions included to anticipate the resident's needs, be sure the call light is in reach and encourage him to use it for assistance The resident had two non-injury falls during the review. Chair/bed alarm is in place. The resident

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needs prompt response to all requests for assistance. Bed in lowest position at night and personal items in reach. Ensure the resident is wearing appropriate footwear when ambulating or mobilizing in his wheelchair. Follow facility fall protocol. Review information on past falls and attempt to determine cause of falls. Record possible root causes.

Review of R23's "Progress Notes" located in the EMR under the "Progress Notes" tab revealed the following falls:

On 12/10/23 at 9:33 AM revealed the resident's roommate was hollering and put on the call light. When entering the room, the resident was sitting on the floor directly in front of his recliner. He had stood up and sat right down on his bottom. No injuries noted. He denied pain and was assisted back in his recliner. The physician and family were notified. At 11:44 AM the resident's daughter-in-law called and requested an alarm be put back on his chair.

On 12/19/23 at 5:20 PM revealed the resident's roommate was hollering. When entering the room, the resident was on the floor right by his bed. He did not have gripper socks on. He said he wanted to get up for the day. No injuries were noted and he denied pain.

On 3/31/24 at 4:32 PM revealed a fellow resident reported that R23 was on the floor. The resident was found sitting on the floor on his bottom in front of his wheelchair. The resident's alarm was on his wheelchair; however, it was not turned on. He denied pain or any injury. The fellow resident said he slid out of his wheelchair and did not hit his head. Family and physician was notified.

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A request was made on 4/9/24 at 2:00 PM to the Administrator for all investigations for all R23's incidents. One hand-written investigation was received for the fall of 3/31/24. No other investigations were received by the exit of the survey.

Review of the "Investigation" provided by the facility and completed by the Administrator on 4/2/24 revealed R23 had a fall on 3/31/24. The investigation revealed R23 slid out of his wheelchair onto his bottom. No injury. Resident does have a personal alarm on his wheelchair and was not sounding. Re-educated CNAs about making sure the alarm is on.

During an interview with the DON and Administrator on 4/10/24 at 3:40 PM revealed the process regarding incidents/falls was the nurse who discovered the incident/fall completed the incident report in point click care (PCC), then it's discussed in Risk Management. The DON said she was responsible for incidents regarding falls and the Administrator said she was responsible to ensure all incident reports were thoroughly investigated and completed. The DON and Administrator confirmed there was only one report for R21's fall on 4/6/24 out of the five falls he had since admission. They both confirmed there was only one report for R23's fall on 3/31/24 out of three falls he had since December 2023. The Administrator confirmed R21's investigation was not completed until 4/10/24 after the investigation was requested on 4/9/24. They both confirmed the investigations for R21 and R23 did not have any possible new interventions and/or root cause analysis in order to potentially prevent further falls.

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to establish a system to accurately reconcile controlled medications using the accepted standards of practice. The	F 755	Facility will review and revise as necessary the Controlled Substance policy to ensure safeguards are in place to control account for, and periodically reconcile controlled medications to prevent loss to ensure narcotic counts. All Staff responsible for controlled substance delivery to the residents will be re-educated on the controlled substance policy to ensure safeguards are in place to control account for, and periodically reconcile controlled medications to prevent loss to ensure narcotics counts are accurate. All other residents MARS will be audited for controlled substances to ensure safeguards are in place to control, accurate for, and reconcile to prevent loss to ensure narcotic counts are accurate. All resident could be affected. Director of nursing or designee will audit narcotic counts on all residents once per week for four weeks and monthly for two more months to ensure narcotic accounts are accurate. Director of Nursing will present audit findings a monthly QAPI meetings for further review and considerations. Hospice was refunded for the wasted morphine. Completed: 05/03/2024	05/03/2024

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facility also failed to have a safeguard in place to control, account for, and periodically reconcile controlled medications to prevent loss for Resident (R) 19. The facility reported a census of 44 residents.

Findings Include:

The facility document titled "Management and Storage of Controlled Substances" revised 3/16/23, stated the purpose was to maintain accurate record and ensured that all controlled substances which may have a high risk of abuse or diversion, would be kept under control, and accessed only by authorized personnel.
o All controlled substances would be recorded on a Controlled Drug Administration Record
o All scheduled II-V controlled substances would be reconciled at the start of each shift by both the on-coming and off-going nurses.
o Charge nurse would immediately report any theft or loss of a controlled substance to the Director of Nursing (DON).
o It would be reported to the DON anytime the count reconciliation was not correct, so the discrepancy could be investigated in a timely fashion.

The Minimum Data Set (MDS) assessment (a federally mandated comprehensive assessment) dated 2/23/24 for R19, listed diagnoses of hypertension (HTN), Alzheimer's, and palliative care.
The Order Summary Report dated 4/11/24, identified an order for morphine sulfate solution 100 mg (milligrams)/5 ml (milliliters), give 0.25 ml (5 mg) every hour as needed for pain or shortness of breath, start date 2/15/24.

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On 4/10/24 at 11:32 AM, with Registered Nurse (RN1) count of the narcotics locked in the East Medication Cart revealed R19 had:

1. One bottle of Morphine 100 mg/5 ml, give 0.25 ml every hour as needed, that contained 12 ml. The Controlled Drug Receipt/Record/Disposition form identified the facility received 15 ml from the pharmacy on 8/24/23. Documented on 8/25/23 at 5 PM the resident received a dose of 0.25 ml, leaving 14.75 ml.

2. One package of 16 individual syringes labeled Morphine 100 mg/ml give 0.25 ml every hour as needed. The Controlled Drug Receipt/Record/Disposition form identified the facility received 16 doses (syringes) from the pharmacy on 8/31/23. Documented on 11/18/23 at 3:10 AM, the resident received a dose of 0.25 ml, leaving 15.75 ml.

RN1 stated she did not know anything about the discrepancy, she was a travel nurse, and would need to follow-up with the Director of Nursing (DON).

The facility document titled "Controlled Drug Change of Shift Reconciliation", documented the facility nurses signed the narcotic count as being accurate before and after every shift from 11/18/23 - 4/10/24.

The facility failed to account for the discrepancy in the amount of liquid morphine bottle that had 12 ml when the count sheet showed the bottle should have contained 14.75 ml and, and the syringe count was sixteen, the count sheet showed 15.75 syringes were left when the count should have been 15.

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Interview on 4/10/24 at 11:45 AM, the DON confirmed the two "Controlled Drug Receipt/Record/Disposition" forms were inaccurate for R19. Per the Controlled Drug form the DON confirmed the pharmacy delivered a 15 ml bottle of morphine prescription (RX)#6160271/001 on 8/24/23 and on 8/25/23 at 5 PM a dose of 0.25 ml was administered with 14.75 mls remaining in the bottle. Jointly reviewed the morphine remaining, and the DON confirmed the bottle of morphine contained 12 mls instead of 14.75 mls. The DON confirmed per the Controlled Drug form the pharmacy delivered 16 syringes of morphine that contained 0.25 mls per syringe to the facility, RX#6180897/001 on 8/31/23 and on 11/18/23 at 3:10 AM the resident was administered 0.25 mls and the documentation revealed 15.75 mls remaining. Jointly reviewed count of the morphine syringes and the DON confirmed, 16 syringes remained with 0.25 mls in each syringe. The DON stated that it appeared the resident was administered two, 0.25 ml doses from the 15 ml bottle and the remainder would have been 14.5 mls. Again, the DON confirmed only 12 mls remained in the bottle. The DON stated R19 could not have been administered a syringe containing 0.25 ml, as still had 16 syringes on hand. The DON stated she would follow up with the Consulting Pharmacist.

Interview on 4/10/24 at 12:45 PM, the DON stated she spoke with the Consulting Pharmacist and was reported that CMS (Centers for Medicare and Medicaid Services) accounted for transfer loss of liquid morphine.

Interview on 4/10/24 at 1:09 PM, the DON stated medication reconciliation was to be completed by two nurses at the beginning and end of each shift,

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confirming all counts are accurate for each resident. The DON stated both nurses are signing off that narcotic count was accurate and completed at the beginning and ending of each shift. The DON stated if there was an incorrect count, the nurse would notify her immediately and she would investigate. The DON stated that usually the counts were off due to a nurse adding and/or subtracting wrong after administering a dose.

Interview on 4/10/24 at 2:17 PM, the Consulting Pharmacist stated she was at the facility monthly and would check the emergency kits and the emergency-controlled medications for expiration dates. The Consulting Pharmacist stated the resident specific controlled medications were to be reviewed by the facility staff, and that she would remind them to verify the counts. The Consulting Pharmacist confirmed there were 16 syringes of 0.25 ml of morphine and the morphine bottle contained 12 ml when only one dose had been documented as administered. The Consulting Pharmacist stated per Appendix PP the SOM (Survey Operations Manual) allowed for discrepancies in liquid morphine. The Consulting Pharmacist confirmed the liquid morphine was a 15 ml bottle and one dose administered would leave 14.75 ml remaining and the current amount in the bottle was 12 ml. The Consulting Pharmacist stated she would follow-up with the pharmacy documentation and records.

Interview on 4/10/24 at 2:56 PM, the Consulting Pharmacist stated she could not account for evaporation and that the morphine narcotic count was inaccurate for R19. The Consulting Pharmacist stated she would have a discussion at the next monthly QAPI (Quality Assurance and

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F 755	Continued From page 72 Performance Improvement) meeting regarding audits, accountability, and miscounts.	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, manufacturer guidelines, and interview, the facility failed to ensure medications used in the facility were stored in accordance with accepted professional principles. The facility failed to discard two insulin pens from the medication cart	F 761	Facility will review and revise as necessary the label/store drugs and biologicals policy to ensure safeguards are in place to and updated as needed. All Staff responsible for labeling of drugs/biologicals of drugs will be re-educated on the labeling and storing policy to ensure safeguards are in place to control account for, and periodically reconcile. All other resident's medication will be audited for correct labeling are in place for accurate medication information. Director of nursing or designee will labeling/store drugs and biologicals on all residents once per week for four weeks and monthly for two more months to ensure narcotic accounts are accurate. Director of Nursing will present audit findings a monthly QAPI meetings for further review and considerations. Medication replaced at facility cost for R 15 and R16 and labeled correctly Completed: 05/03/2024	05/03/2024

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28 days after opening. The facility reported a census of 44 residents.

Findings include:

1. The Minimum Data Set (MDS) assessment (a federally mandated comprehensive assessment) for R15 dated 12/28/23, identified a Brief Interview for Mental Status (BIMS) score of 5, indicated severe cognitive impairment. The MDS documented diagnosis of diabetes. The MDS recorded the resident received insulin injections daily in the last 7 days.

The Order Summary Report for R15 dated 4/11/24, identified an order for Novolog (fast acting insulin) flex pen, inject per sliding scale subcutaneously three times a day for diabetes.

2. The MDS assessment for R16 dated 1/26/24, identified a BIMS score of 8, indicated moderate cognitive impairment. The MDS documented diagnosis of diabetes. The MDS recorded the resident received insulin injections daily in the last 7 days.

The Order Summary Report for R16 dated 4/22/24, identified orders for:
a. Novolog flex pen, inject 4 units subcutaneously one time a day for diabetes.
b. Novolog flex pen, inject 8 units subcutaneously two times a day for diabetes.
c. Novolog flex pen, inject per sliding scale subcutaneously three times a day.

Observation of the west medication cart on 4/10/24 at 11:10 AM, with the Certified Medication Aide 1 (CMA1) and the Registered Nurse (RN1) revealed:

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F 761	Continued From page 74	F 761		

a. Novolog flex pen for R15 with an expiration date of 4/2/24
b. Novolog flex pen for R16 with an expiration date of 4/8/24

CMA1 stated she did not administer insulin to the residents and was unable to explain the documented expiration dates.

RN1 stated she would say the insulin pens were dated when they were opened and not when they expired due to the syringes containing insulin. RN1 proceeded to state she was a travel nurse, and the Director of Nursing would need to confirm the expiration dates. RN1 confirmed the other three insulin pens were dated with future expiration dates. RN1 confirmed the label on the insulin pen for R15 had an expiration date of 4/2/24 and the insulin pen for R16 had an expiration date of 4/8/24. RN1 stated she administered R15's morning dose of insulin from the pen that expired 4/2/24.

The manufacturer package insert for NovoLog flex pen stated the pen could be stored at room temperature for 28 days and after that, throw away the pen even if it contained insulin.

Interview on 4/10/24 at 4:55 PM, the Director of Nursing (DON) stated she expected the nursing staff to date the insulin pens 28 days after opening with the expiration date. The DON stated there were nurses that would document the date opened instead of the expiration date even though the sticker identified the date as the expiration date. The DON stated she had provided education to the nursing staff regarding expiration dates of the insulin pens and had provided the nursing staff with a wheel for

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F 761	Continued From page 75 determining expiration dates 28 days after opening. The DON stated she had identified the issue and had provided education directly to the nursing staff, however, denied having documentation of education that had been provided and/or that a performance improvement plan had been initiated.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:	F 803	All policy regarding Menus Meet Resident Needs/Preparing in Advance/Followed have been reviewed and updated as needed. Staff was educated on Menu substitution policy. Cooks brought up old menu items that we no longer use. Menus will be revised to ensures compliance. Inservice was preformed to staff to puree and ground food properly. Also trained to bread crumbs in diet as well. Dietary Manager or designee will preform audits once weekly for four weeks then monthly for two months. Will present audit findings at QAPI meetings. Completed: 05/03/2024	05/03/2024

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F 803	Continued From page 76	F 803		

Based on observations, record review, and interview, the facility failed to follow the menu and substituted items. The facility failed to offer the same menu to ten residents who received puree and/or ground meat. The facility also failed to follow the process when preparing the pureed diets. The facility reported a census of 44 residents.

Findings include:

The facility document titled Menu Substitutions Policy dated 1/5/24, stated the facility would serve food according to the menu and follow the menu breakdown as posted. In the event that substitutions must be made at a meal, foods or beverages would be of equal nutritional value.

Menu for the Noon meal on 4/10/24:

1. Roast Pork.
2. Mashed potatoes and gravy.
3. Creamed cabbage.
4. Diced peaches.
5. Bread/margarine. Pureed identified 1 ounce of breadcrumbs.
6. Milk

On 4/10/24 at 9:31 AM, the Dietary Manager (DM) stated the menu identified pork roast, however, he only had one pork roast available and that would not be enough to serve all the residents and staff so he would be substituting pork chops. The DM stated he would also be serving carrots in place of cream cabbage. The DM stated the dietitian had approved a list of substitutes for menu items. The DM prepared 2 pureed diets for the noon meal and utilized ground sausage in place of the pork chops. The DM utilized brown gravy and chicken gravy for

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F 803	Continued From page 77 sauce with the puree sausage and then proceeded to add beef broth as needed for additional liquid. The DM prepared each food item individually, washing the food processor in between. The DM failed to include breadcrumbs in the meat puree as indicated on the menu. Interview on 4/10/24 at 12:45 PM, the DM confirmed he failed to include breadcrumbs with the pureed sausage, stated he was not aware that breadcrumbs were identified on the daily menu. The DM stated the facility had new admissions and with the facility staff eating, he had difficulty determining the number of meals he had to serve at each meal. The DM stated he was unable to serve the pork roast due to only having one available and that would not feed residents and staff, so he served the pork chops. The DM stated he had to utilize ground sausage for the ground diets and the pureed diets due to a case of pork chops only contained 40 pieces and would not have enough pork chops for residents and staff if he ground and pureed the pork chops. The DM confirmed he served one resident pureed sausage and 9 residents ground sausage instead of the pork chops. Interview on 4/10/24 at 4:51 PM, the Administrator stated she expected the DM to follow the menu.	F 803		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812	All policy regarding Food Procurement Store/Prepare/Serve-Sanitary have been reviewed and updated as needed.	04/19/2024

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F 812	Continued From page 78 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. The facility reported a census of 44 residents. The failure had the potential to affect 43 residents. Findings include: On 4/8/24 at 2:25 PM, during the initial tour of the kitchen, with the Dietary Manager (DM) observations in the dry pantry storage revealed: 1. Three, 12.8-ounce packages of tapioca pudding mix with use by date of 12/2023. 2. One, 57-ounce box of potato pearls opened and not dated. 3. One bag of dry elbow macaroni, half used, opened, and not dated. 4. One bag of dry egg noodles, half used, opened, and not dated. 5. One bag of pancake mix opened and undated.	F 812	All staff responsible for food preparation and handling of food will be re-educated on food preparation and handling policy to ensure all food items served to the residents will be prepared according to recipes and food will be received, checked, and stored properly. Dietary Manager or designee will perform audits once weekly for four weeks then monthly for two months to ensure that food items served to the residents will be prepared according to recipes and food will be received, checked and stored properly. Dietary Manager will present the audits finds at the monthly QAPI meetings for further receive and considerations. Completed: 04/19/2024	

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F 812	Continued From page 79 6. One box of rice opened and undated. The DM confirmed the pudding mix was expired and the food items had been opened and were undated. The DM removed the items from the dry pantry storage. The facility document titled Food Preparation and Handling Policy, undated, stated all food items served to the resident's would be prepared in a central kitchen according to standardized recipes and food would be received, checked, and stored properly. Interview on 4/10/24 at 4:51 PM, the Administrator stated the state agency had identified expired items in the kitchen. The Administrator stated she expected food items to be dated once opened and expired foods to be discarded.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and	F 851	Business Office Manager reeducated on proper PBJ submission and timeliness. Outside consultant was engaged to ensure proper PBJ submissions and timeliness. Administrator will audit PBJ submission monthly for 3 months to ensure proper PBJ submission and timeliness. Administrator will present audits at monthly QAPI meetings for review and consideration.	04/12/2024

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F 851	Continued From page 80	F 851		

services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).

§483.70(q)(2) Submission requirements.
The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following:
(i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS);
(ii) Resident census data; and
(iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual).

§483.70(q)(3) Distinguishing employee from agency and contract staff.
When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency.

§483.70(q)(4) Data format.
The facility must submit direct care staffing information in the uniform format specified by CMS.

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F 851	Continued From page 81	F 851		

§483.70(q)(5) Submission schedule.
The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly.
This REQUIREMENT is not met as evidenced by:
Based on interview, review of staffing schedules, time punches, and review of the "Payroll-Based Journal (PBJ)" submitted to the Centers for Medicare and Medicaid (CMS), the facility failed to ensure data was accurate that was submitted to CMS related to direct care staffing and excessively low weekend staffing for Fiscal Year (FY) 2023 for three quarters out of three quarters reviewed for "PBJ" for 2023. The facility also failed to submit any data for FY Quarter 3, 2023. This had the potential to affect all the residents of the facility.

Findings include:

Review of the "PBJ" report from CMS for FY Quarter 1, Quarter 2, and Quarter 4, 2023 revealed the facility failed to have licensed nursing staff coverage for 24 hours a day and had significantly low weekend staffing. Further review of the "PBJ" report from CMS revealed no data was submitted by the facility for FY Quarter 3.

Review of the "Staffing Schedules" provided by the facility for 2023, including time punches, as well as electronic medical records (EMRs) documentation revealed the facility had licensed nursing coverage 24 hours per day and had sufficient staffing on the weekends for 2023.

During an interview with the Administrator on 4/10/24 at 4:15 PM, she confirmed she was responsible for ensuring accurate data was

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F 851	Continued From page 82 submitted to CMS for the "PBJ." She said there were issues with logging in when she tried to submit data for FY Quarter 3. She said she was one day late trying to submit the information and CMS closed it and she could not get back in to submit the data. She said she called CMS and they told her she was too late. She also confirmed the data submitted for FY Quarter 1, 2, and 4 was not accurate as the facility did have 24 hours per day of nursing coverage and had sufficient staffing on the weekend. She said the staffing information was from their time keeping system (TKS) and said it was hard to read resulting in the inaccuracy of the data submitted to CMS.	F 851		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867	Administrator will review and revise as necessary the quality assurance performance improvement (QAPI) process to ensure policy is all encompassing of the care of the residents and that the staff that participate are engaged in the policy. The administrator has implemented a new QAPI program to ensure the program covers all departments and all areas of resident care including but not limited to infection control, skins, medication administration, personnel management and many others. All residents are possibly affected by this policy so administration will ensure appropriate implementation of this QAPI program.	05/01/2024

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F 867	Continued From page 83 not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to	F 867	All staff will be educated on the necessity of implementation of this QAPI program. Administrator will audit the implementation of this QAPI program once per month for three months to ensure the successful implementation of this QAPI program. Administrator will present audit findings at the monthly QAPI meetings for review and consideration. Completion Date: 05/01/2024	

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F 867	Continued From page 84	F 867		

ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)

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

(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee made good faith attempts to identify and correct quality deficiencies when they did not develop or implement appropriate action plans/performance improvement plans (PIPS) to correct on-going, systemic issues. This deficient practice had the potential to affect all the residents in the facility. The facility reported a census of 44.

(Reference F609-J, F610-J, and F689-K.)

Findings include:

Review of the 7/1/23 facility "Quality Assurance Performance Improvement (QAPI)" plan recorded the QAPI program would aim for safety and high quality with all clinical interventions and service ....by ensuring data collection tools and monitoring systems were in place and were consistent for proactive analysis, system failure analysis, and corrective action. The plan further recorded the QAPI committee would utilize the best available evidence to define and measure

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their goals. Additionally, the plan recorded that the facility would seek input from nursing center staff, residents, their families, and other stakeholders and develop performance improvement plans (PIPs) to examine and improve care or services in areas that the nursing center identified as needing attention.

The facility did not provide a policy for QAPI and failed to provide a QAPI agenda that identified the areas of concern.
1. There was no evidence identified how the facility established QAPI goals.
2. There was no evidence identified related to how the facility would report, monitor, and reassess QAPI goals for the success and overall effectiveness of the goals.
3. There was no evidence which exhibited what corrective measures would be taken to correct identified problems and promote quality of care.
4. There was no evidence exhibited how the facility would monitor its own performance measures and departmental oversight of the established goals.
5. There was no evidence exhibited the facility would track and trend outliers in care and quality measures.

Review of the facility "QAPI Agenda Meeting Minutes" recorded the following:

3/26/24-The QAPI committee reviewed "advice from the Medical Director regarding influenza" but lacked documentation of what specifically was reviewed.
2/23/24- The QAPI committee reviewed "falls" but lacked documentation of what specifically was reviewed.
1/31/24- The QAPI committee reviewed "weights"

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F 867	Continued From page 87	F 867		

but lacked documentation of what specifically was reviewed.
12/6/23-The QAPI committee reviewed "staffing" but lacked documentation of what specifically was reviewed.
10/11/23- The QAPI committee reviewed "Quality Measures" but lacked documentation of what specifically was reviewed.
9/7/23- The QAPI committee reviewed "skin integrity" but lacked documentation of what specifically was reviewed.
8/16/23- The QAPI committee reviewed "call audits" but lacked documentation of what specifically was reviewed.
7/10/23- The QAPI committee reviewed "flooring" but lacked documentation of what specifically was reviewed.
6/8/23- The QAPI committee reviewed "outside grounds" but lacked documentation of what specifically was reviewed.
5/31/23- The QAPI committee reviewed "laundry" but lacked documentation of what specifically was reviewed.
3/20/23- The QAPI committee reviewed "Infection Control" but lacked documentation of what specifically was reviewed.

No "QAPI Meeting Minutes" were provided by the facility for April or November 2023.

None of the "QAPI Meeting Minutes/Agenda" provided by the facility reflected that any ongoing performance improvement plans were developed, implemented, or evaluated for their effectiveness throughout the past 12 months, and lacked identification of deficient practice and/or systemic failures by the facility QAPI committee.

During an interview on 4/20/24 at 4:03 PM, the

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F 867	Continued From page 88 Administrator indicated that the QAPI committee did not have any PIPs in place that the facility was actively working on. The Administrator further indicated that the QAPI committee had not identified any issues related to Abuse and Neglect, Incidents and Accidents, Infection Control, care plans, food storage, and/or grievances and did not have any PIPs in place for any of the identified deficient areas. Additionally, the Administrator indicated that she looked at the quality measures to try and identify things for the facility to work on and if a department had "something burning" they needed to work on, and there was not currently a process for staff or resident suggestions and if a family member needed something they just called or texted someone at the facility but there was not an official form or process to identify items to review in QAPI.	F 867		
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, reporting, investigating, and controlling infections	F 880	The administrator, DON and infection preventionist in consultation with the medical director, Pharmacist and whomever else identified will review, revise, create as necessary policies and procedures about: Infection prevention and control program (IPCP) that will include, at a minimum, the following elements: An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. IP, Environmental Services director, and Administrator implementing water management program. Administrator, DON, and other	05/01/2024

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F 880	Continued From page 89 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 corrective actions taken by the facility.	F 880	designated staff will complete infection control specific QAPI meeting with Root cause analysis (RCA) identifying the five "whys" (step 5) with plan for correction to be monitored weekly for 4 weeks decreased to bi-monthly, then monthly with continued monitoring through monthly QAPI meeting. Designated staff will be educated on how and when to use pharmacist recommended/pharmacy provided SBAR physician antibiotic request forms to ensure specific criteria is met per antibiotic stewardship guidelines. LPN has completed education for IP position. Completed: 05/01/2024	

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F 880	Continued From page 90	F 880		

§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 interview and record review, the facility failed to implement an infection surveillance plan to ensure early detection and management of potentially infectious diseases, lacked ongoing analysis of surveillance data and documentation, and failed to develop and implement a water management plan to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems. The deficient practice had the potential to affect all the residents in the facility. The facility reported a census of 44.

Findings include:

Review of a document titled, "Centers for Disease Control (CDC) . . . National Healthcare Safety Network (NHSN) . . . Long Term Care Facility Component Tracking Infections in Long-Term Care Facilities . . .," dated 01/20, indicated, " ... Surveillance is defined as the ongoing systematic collection, analysis, interpretation, and dissemination of data. A facility infection prevention and control (IPC) program should use surveillance to identify infections and monitor performance of practices to reduce infection risks among residents, staff, and visitors. Information collected during surveillance activities can be

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F 880	Continued From page 91	F 880		

used to develop and track prevention priorities for the facility. When conducting surveillance, facilities should use clearly defined surveillance definitions that are collected in a consistent way. This method ensures accurate and comparable data regardless of who is performing surveillance . . ."

Review of the facility policy titled, "Infection Prevention and Control Program," revised 7/24/14 indicated ". . . maintains an organized, effective facility-wide program designed to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors and healthcare workers. The IP responsibilities for infection prevention and control include but may not be limited to . . . Conducts surveillance for facility associated infections and/or communicable diseases . . . In collaboration with Administration and Medical Director . . . Communicates infection prevention and control data to facility leadership, appropriate leadership committees, facility staff, public health department . . . "

1. Review of the "Infection Control Binder/Antibiotic Log" reflected no residents in the facility received any antibiotics or had active infections for the month of April.

During an interview on 4/9/24 at 11:12 AM, the Director of Nursing (DON) indicated that she had not recorded any of the April antibiotics or infections for the month yet "because the month was not over yet" and she would record April's information on antibiotic use and infections after the month was completed. The DON further indicated that she did not understand that she needed to do ongoing surveillance and tracking

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F 880	Continued From page 92	F 880		

throughout the month and thought it [infections and antibiotics] could all be recorded at the end of the month once the month was completed.

Review of the April 2024 "Monthly ABX Tracking" Log provided by the DON, separate from the "Infection Control/Antibiotic Log", recorded three residents' first name and last initial, with the name of the antibiotic the resident was on, the type of infection the resident had, and that no cultures were obtained. The monthly log lacked the full name of the resident, the date the antibiotic was started, and the dose and duration of the antibiotic for each resident.

During an interview on 4/9/24 at 3:12 PM, the DON indicated that she had "just filled this form out real quick because she had not started the log yet for April" and she had not taken the time to add the additional information.

During a subsequent interview on 4/10/24 at 3:55 PM, the DON indicated that she kept track of infections and antibiotics in her head as this was a small facility, so she typically did not write anything down for tracking for the month until the beginning of the next month.

2. Review of the facility policy "Water Management Plan-Legionella (bacteria found in water)" revised on 2/22/24 recorded the purpose of the policy was to decrease the risk of transmission of waterborne pathogens (illnesses caused by organisms in untreated or contaminated water), the facility would monitor and maintain hazard controls (disinfectant levels ad temperatures) within building water system and would flush faucets and showers in unoccupied inpatient care areas on a weekly

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F 880	Continued From page 93 basis. Review of the undated facility "Environmental Risk Assessment" provided by the Maintenance Director (MD) reflected that the facility failed to complete any portion of the "Environmental Risk Assessment". During an interview on 4/9/24 at 2:20 PM, the MD indicated that he had heard about the facility's need for a water management plan at a seminar last fall, but he had not developed or implemented the water management plan for the facility. The MD further indicated that he had printed off the Centers for Disease Control (CDC) tool kit for Legionella and other opportunistic waterborne pathogens but he "did not know what he was supposed to do with it" and had not received any direction from the facility Administration as to what he was supposed to do. Additionally, the MD indicated that he tried to make sure the toilets were flushed, and the sinks were turned on in unoccupied resident rooms on a weekly basis, but he did not record this information anywhere he just tried to keep track of it in his head. During an interview on 4/10/24 at 4:30 PM, the Administrator indicated that she was not aware that the MD had not developed or implemented the Water Management Program for Legionella and other opportunistic waterborne pathogens. The Administrator further indicated that she had expected that the MD had completed the required assessment for development of the plan for the facility and was not aware the assessment was blank.	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role	F 882		

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F 882	Continued From page 94 CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure they designated a specific individual as the Infection Preventionist who had received specialized training in Infection Prevention and Control and was responsible for the facility Infection Control Program. This had the potential to affect all the residents in the facility. The facility reported a census of 44. Findings include: During an interview on 4/10/24 at 4:00 PM with the Director of Nursing (DON) and Administrator, both confirmed the facility did not have an Infection Preventionist as the last one had quit in November 2023. The DON further indicated she and the Minimum Data Set (MDS-a federally	F 882	Administrator, DON and designated staff will review and revise how Infection Prevention and Control Program (IPCP) audits, competencies and antibiotic use are completed and documented. Administrator, DON, and other designated staff with consult from medical director and pharmacist will educate infection preventionist on properly documenting audits competencies antibiotic use and other items monitored by the infection preventionist for presenting usable data at monthly QAPI meeting. LPN has completed education for IP position. Infection preventionist will be provided remedial training in Infection prevention and control program (IPCP) with mentor-ship by experienced IP. Progress will be monitored weekly for 4 weeks then twice monthly for one month then monthly with data documentation brought forth to QAPI meeting. Completed: 05/01/2024	05/01/2024

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F 882	Continued From page 95 mandated assessment tool) Coordinator were "trying to get the stuff in order and sharing the duties for Infection prevention and control". Additionally, the DON indicated that she had not completed the training for the Infection Preventionist, but she had started the modules. During an interview on 4/8/24 at 3:35 PM, the MDS Coordinator confirmed that she had not completed the Infection Preventionist training and was just trying to help until the facility hired another Infection Preventionist.	F 882		