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	435129	A. BUILDING _____ B. WING _____	C 01/16/2025

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DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/14/25 through 1/16/25. Dells Nursing and Rehab Center Inc was found not in compliance with the following requirements: F609, F657, F686, F689, F692, F760, F851, F880, and F881. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/14/25 through 1/16/25. Areas surveyed included resident safety related to a resident elopement and a potential missing resident medication. Dells Nursing and Rehab Center Inc was found to have past non-compliance at F602.	F 000	Mandatory all staff scheduled for 2/18/25 to discuss all necessary items.	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview, record review, policy review, and review of the South Dakota Department of Health (SD DOH) facility reported incident (FRI), the provider failed to ensure a controlled medication (medication with potential for abuse and addiction) for one of one sampled resident (41) had remained secured and was accounted for. This citation is considered past	F 602	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Togel
TITLE: Administrator
(X6) DATE: 2/11/2025

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F 602	Continued From page 1	F 602		

non-compliance based on a review of the corrective actions the provider implemented following the incident.
Findings include:

1. Interview on 1/16/25 at 8:40 a.m. with registered nurse (RN) D regarding resident narcotic medication counting at the end of her shift revealed:
*She had counted the resident narcotics when she had arrived to begin her shift on 11/23/24 6:00 a.m. with no discrepancy identified.
*RN D did not count the resident narcotics with licensed practical nurse (LPN) R at the end of her shift on 11/23/24 at 6:30 p.m.
*RN D had not left her shift and not counted resident narcotics before 11/23/24 at 6:30 p.m.
*LPN R refused to do the narc count until RN D insisted on it.
*She had been notified on 11/24/24 at 6:25 a.m. by administrator A to return to work and help locate the morphine sulfate (a controlled pain medication) liquid that had been missing.
*RN D had called LPN R on 11/24/24 at 7:00 a.m. and LPN R had already left the facility without locating the missing medication.

2. Interview on 1/16/25 at 10:30 a.m. with nurse manager C regarding the missing morphine sulfate revealed:
*She had been notified on 11/24/24 that six milliliters (ml) of morphine sulfate liquid had not been accounted for.
*Nurse manager C had been working with the pharmacy to complete the investigation of the missing medication and staff education that had been completed on 12/19/24.
*LPN R had been instructed to stay at the facility until RN D arrived to help locate the missing

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F 602	Continued From page 2 medication. *She had not thought that the missing medication would have been considered theft until the pharmacy had informed her that the missing medication was theft. 3. Interview on 1/16/25 at 11:50 a.m. with pharmacist T regarding the missing medication revealed: *He had been informed on 11/24/24 of the missing six ml of morphine sulfate. *Pharmacist T had been involved with the investigation of the missing medication. *He had helped with providing education to staff regarding medication safety, procedures and regulations. 4. Review of the controlled drug receipt/record/disposition form for resident 41's liquid morphine sulfate revealed the last dose of morphine sulfate had been administered on 11/16/24 at 5:00 a.m. with six ml remaining in the bottle. 5. Review of the provider's undated Narcotic Count Policy revealed: *"Narcotics will be counted by licensed nursing personnel to assure they are properly accounted for at the beginning and ending of each shift." *"The ongoing and off going nurse at shift change will perform a physical count of the narcotic drawer." 6. The provider implemented changes to ensure the deficient practice does not recur was confirmed on 1/16/25 after record review revealed the facility had followed their quality assurance process, education was provided to all staff who were approved to administer medication	F 602		

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F 602	Continued From page 3 regarding the regulations for controlled substances, that a system to account for controlled medication is in place and followed, receipt and disposition of medication, a shift-to-shift controlled medication count is completed by the appropriate staff to ensure accurate reconciliation of medications on hand, interviews revealed staff understood the education provided regarding those topics, and observation of controlled medication count compared to the medication supply on hand was accurate. Based on the above information, non-compliance at F602 occurred on 11/24/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 1/16/25, the non-compliance is considered past non-compliance. Review of education provided on 12/19/24 to all staff that administer medication revealed: *Regulations for controlled substances require facilities have a system to account for controlled medication, receipt and disposition in sufficient detail to ensure accurate reconciliation. *A shift-to-shift count is required to pass responsibility and accountability of controlled medication. Education was provided on 12/19/24 to all staff that administer medication regarding controlled medication regulations and accountability of those medications, including liquid medications. 7. Education was provided on 12/19/24 to all staff that administer medication regarding controlled medication regulations and accountability of those medications, including liquid medications.	F 602		

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F 609 F 609 SS=D	Continued From page 4 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 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, and policy review the provider failed to report the missing controlled medication (medications with potential for abuse and addiction) had been reported timely to SD DOH.	F 609 F 609	Unable to correct past noncompliance of reporting in a timely manner. This deficiency has the potential to affect all residents. Administrator, DON, medical director and interdisciplinary team will review and revise policies and procedures as necessary. Counting policy was implemented in December following the November incident. Administrator, DON, ADON, and MDS Coordinator will be educated with documentation on reporting and reporting timelines along with any updated policies and procedures by 2/20/25. DON or designee will audit reportable incidents being reported in correct time weekly for 4 weeks and monthly for 2 additional months. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	2/20/25

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F 609	Continued From page 5 Findings include: 1. Review of the provider's 12/4/24 SD DOH FRI revealed on 11/24/24 six milliliters (ml) of morphine sulfate (a controlled pain medication) had been unaccounted for. 2. Interview on 1/16/25 at 11:28 a.m. with nurse manager C regarding the reporting the missing controlled medication revealed: *She had not known the timeline requirement for reporting the missing controlled medication to SD DOH. *She had not known that the missing medication could be considered theft of personal belongings. *She had known that she had not followed the facility's policy for reporting the potential diversion of a controlled substance. *On 11/25/24 she had begun the paperwork the pharmacy had provided her for drug diversion. *The pharmacy had informed her that it was a misappropriation of a personal item on 12/4/24. 3. Interview on 1/16/25 at 12:16 p.m. with administrator A regarding the reporting of the missing controlled medication revealed: *She had not been aware of the timeline for reporting missing medication to the SD DOH. *Administrator A agreed that she had not followed their policy for reporting the potential diversion of a controlled substance. Review of the provider's undated Reporting and Investigating Diversion of Controlled Substances Policy revealed: *"The investigation will be conducted with the assistance of human resources and will be completed within 48 hours of the incident's	F 609		

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F 609	Continued From page 6 discovery." *"Severity of the theft or loss must be evaluated when considering reporting." *"Agencies to whom narcotic thefts may be reported include local office of OHS licensing."	F 609		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 657	Resident 4, 9, 34, 7, 10, and 11's care plans have been revised and updated by MDS coordinator. Unable to correct resident 29's care plan due to them no longer residing in facility. This deficiency has the potential to affect all residents. MDS coordinator and others as necessary will be educated with documentation on care planning. Care plans on 8 residents per week for 6 weeks will be reviewed, revised, and updated quarterly and as needed to reflect their current needs. DON, MDS Coordinator, SSD, Activities Director, and Administrator will update information on care plans. Administrator, DON, medical director, and interdisciplinary team will review and revise policies as necessary. DON or designee will audit 3 care plans once per week for 4 weeks, and monthly for 2 additional months or longer as determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	2/20/25

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F 657	Continued From page 7	F 657		

and policy review the provider failed to ensure resident care plans had been revised to reflect their current needs for:
*Three of three sampled residents (4, 9 and 34) who had fallen.
*One of one sampled resident (7) who had a facility acquired pressure ulcer.
*One of one sampled resident (10) who had a history of urinary tract infections.
*One of one sampled resident (11) who developed a facility acquired pressure sore.
*One of one sampled resident (29) who had attempted to leave the facility without staff knowledge.
Findings include:

1. Review of resident 34's electronic medical record (EMR) revealed:
*She had fallen on 8/25/24, 10/12/24, and 12/28/24.
*On 12/28/24 resident 34 had an injury after her she fell and required a laceration repair above her left
eye in the emergency room.
*On 8/14/24 the care plan had identified her as at risk for falls.

Interventions on the 8/14/24 initiated care plan included a physical therapy evaluation to treat as needed and to follow the facility's fall protocol.

Interview on 1/15/25 at 2:00 p.m. with Minimum Data Set (MDS)/director of nursing (DON) B regarding interventions for resident 34 due to her falls revealed:
*She had an intervention for physical therapy (PT) to evaluate and treat as ordered initiated on 8/14/24.
*MDS/DON B stated that the facility's fall protocol

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F 657	Continued From page 8 was the same as their fall policy. 2. Observation and interview on 1/14/25 at 8:26 a.m. of resident 10 while in her room revealed: *She was sitting in her recliner working with an occupational therapist. *Her goal was to get stronger and go to assisted living. *She had been in the hospital recently for an infection. Review of resident 10's EMR revealed: *She was admitted on 3/6/24. *Her diagnoses included: -Chronic kidney disease, stage four. -Type two diabetes mellitus without complications. -Retention of urine, unspecified. -History of urinary tract infection. *Her 1/14/25 revised care plan had an intervention to monitor for signs and symptoms of infection, UTI (urinary tract infection) initiated on 3/27/24. *She had orders for antibiotics to treat a UTI on 8/20/24, 8/21/24, 9/9/24, 10/21/24, 11/19/24, 12/6/24, and 12/16/24. *No updates to the care plan were implemented regarding resident 10's UTIs since 3/27/24. Interview on 1/16/25 at 10:05 a.m. with CNA G regarding resident 10's UTIs revealed: *She had been instructed to watch for changes in her behavior that would indicate a UTI. *She would report any changes to the charge nurse. *If a UTI was suspected they would put a "hat" in her toilet to collect a urine sample. *She did not have access to the residents' care plans.	F 657		

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F 657	Continued From page 9 Interview on 1/16/25 at 1:05 p.m. with MDS/DON B regarding resident 10's care plan revealed: *The interdisciplinary team would review resident care plans and make changes as needed. *If changes were made that information was communicated to staff in the pocket care plans (a print out of residents' basic needs for staff to follow). *It was her expectation the care plans would be updated with any significant health issues that would arise. *She agreed resident 10's care plan should have been updated to reflect her care needs related to UTIs. 3. Review of resident 29's electronic medical record (EMR) revealed: *She had opened the front door and started to exit the facility on 12/14/24 at 3:35 p.m. -Alarms sounded and alerted the staff. -She was observed by registered nurse (RN) D standing in the doorway with her walker. -She had been assisted back into the building by RN D. -Her vital signs were taken, were within normal limit, and were documented. *The incident was documented in her chart. -Her family, provider, nurse manager C, and administrator A were notified. *The Elopement Risk Tool completed by RN D on 12/14/24 at 3:50 p.m. -Identified resident 29 was at risk for elopement *Her diagnoses included: -Vascular dementia (brain damage caused by multiple strokes) with psychotic disturbance. -Adjustment disorder. -Weakness. -Hypertension. *She had a Brief Interview for Mental Status	F 657		

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F 657	Continued From page 10	F 657		

(BIMS) assessment score of 12 which indicated she had moderate cognitive impairment.
-There was an order dated 12/31/24 to switch out monitors twice daily to recharge for safety monitoring.
*Her care plan did not indicate she was at risk for elopement.
-No interventions were indicated on her care plan following the above attempted elopement incident on 12/14/24.

Interview on 1/15/25 at 2:17 p.m. with registered nurse D revealed:
*She had started 30-minute visual checks on resident 29 following the above attempted elopement.
-They continued those checks for 24 hours.
-Then hourly visual checks were completed during the day.
-From 8:00 p.m. to 8:00 a.m. she would have been on 30-minute visual checks.
*She completed the Elopement Risk Tool on 12/14/24.
-That identified resident 29 as at risk for elopement.
*Care plans were to be updated by MDS/DON B.
*She was unsure if a tile alarm device was used on resident 29 following the incident.

Interview on 1/15/25 at 3:00 p.m. with MDS/DON B revealed:
*Regarding resident 29's elopement risk they would have considered her behaviors not the score on the assessment.
*On 10/18/24 her elopement risk score was 10, and she was not considered an elopement risk at that time.
*The elopement risk assessment score of 25 completed on 12/14/24, identified her as at risk

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for elopement.
*She agreed resident 29's care plan should have been updated after interventions were initiated.
*Nurse manager C and administrator A would decide on the use of tile device alarms. As an elopement prevention intervention.
*She agreed resident 29's care plan had not been updated to following the above attempted elopement or any interventions put in place.

Interview on 1/15/25 at 3:00 p.m. with administrator A and nurse manager C revealed:
*Resident 29 had used a tile device following the above incident on 12/14/24.
-Her family had approved and consented to the use of the device.
*They would have expected the care plan to have been updated following the elopement.
*Elopement education was provided to staff following resident 29's elopement on 12/14/24.
*Behavioral health had recommended memory care placement for resident 29.
4. Observation on 1/14/24 at 9:09 a.m. with resident 4 in the dining room revealed:
*She was seated in her wheelchair.
*She had an electronic monitoring device on her wrist.

Review of resident 4's electronic medical record (EMR) revealed:
*She was admitted on 5/23/24
*She had a Brief Interview of Mental Status (BIMS) assessment score of 8, which indicated she was moderately cognitively impaired.
*Her diagnoses included cellulitis, dementia, and bulbous pemphigoid (an autoimmune disease that causes skin blisters).
*She had fallen on 8/9/24, 8/13/24, 8/14/24, 8/15/24, 8/28/24, 9/9/24, 10/10/24, 10/11/24,

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F 657	Continued From page 12 10/13/24, and 12/18/24. *She had an electronic monitoring device on her wrist that would alarm to alert staff of position changes as a fall prevention. *There was no documentation of interventions in her care plan that addressed fall prevention since her admit date on 5/23/24. 5. Observation and interview on 1/14/24 at 10:35 a.m. with resident 9 in her room revealed: *She was seated in her wheelchair listening to an audiobook. *She had a full body mechanical lift sling underneath her. *She had recently fallen. *She used her walker for transfer assistance before she had fractured her ankle. *She was transferred with the use of a full body mechanical lift and the assistance of two staff. Review of resident 9's EMR revealed: *She was admitted on 2/14/24. *She had a BIMS assessment score of 11, which indicated she was moderately cognitively impaired. *Her diagnoses included chronic obstructive pulmonary disease, Parkinson's disease, and hypertension. *She had fallen on 10/27/24, 10/28/24, 11/3/24, 12/9/24, 12/19/24, 12/20/24, and 12/22/24. *There was no documentation of interventions in her care plan that addressed fall prevention since her admit date on 2/14/24. Interview on 1/15/25 at 1:01 p.m. with registered nurse (RN) D revealed: *MDS/DON B updated the residents' care plans and the pocket care plans. *Hired agency workers and staff referred to the	F 657		

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pocket care plans to help care for residents' needs.

Interview on 1/15/25 at 3:28 p.m. with MDS/DON B regarding resident care plans revealed:
*She updated the resident's care plans and pocket care plans.
*She stated the care plans should be updated when a new intervention was added for a resident.
*She confirmed that residents 4 and 9 did not have new interventions documented on their care plans after their fall incidents.
*She confirmed the care plans should be updated to provide appropriate care for the residents' needs.

Interview on 1/16/25 at 8:32 a.m. with nurse manager C regarding resident care plans revealed:
*DON B was responsible for updating residents care plans.
*The interdisciplinary team (IDT) would meet daily at 10 a.m. to review resident falls that occurred during the night and discuss interventions to implement.
*Her expectation was that DON B would update and document the interventions in the residents' care plans after the IDT meetings.
*She was not aware that fall interventions were not documented for residents 4 and 9 in their care plans.
*She had the capability to update the pocket care plans if it was needed.
6. Observation and interview on 1/14/24 at 9:02 a.m. with resident 7 revealed:
*There were two cushions in her wheelchair.
*The top cushion was a waffle cushion that covered the bottom and back of the wheelchair.

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F 657	Continued From page 14 *The cushion under the waffle cushion was a Roho cushion (air cushion that helps distribute weight evenly to prevent pressure ulcers). *The Roho cushion was not inflated. *Resident 7 transferred herself to her recliner. *There was no cushion in the recliner. *Resident 7 stated that her daughter brought her the waffle cushion for her "comfort". *She did not remember if she had any sores or skin problems. Review of resident 7's electronic medical record (EMR) revealed: *She was admitted on 5/30/24. *Her 12/7/24 brief interview for mental status (BIMS) assessment was 12, which indicated moderate cognitive impairment. *Her diagnoses included dementia, repeated falls, and weakness. *She had a stage II pressure ulcer (a shallow open ulcer that resulted due to pressure) identified on 11/16/24. *The stage II pressure was documented as healed on 12/6/24. *She was prescribed mirtazapine with an "Indication for Use: antidepressant". *She did not have a diagnosis of depression. Review of resident 7's 1/14/25 care plan revealed: *She had a focus area of "I have the potential to have impairment to skin integrity" which was initiated on 5/30/24 and updated on 6/3/24. *The use of the ROHO cushion or the waffle cushion was not included in the care plan. *A focus area of "I have a potential nutritional problem r/t [related to] hx [history] of CHF [congestive heart failure]; COPD [chronic obstructive pulmonary disease] and recent hip	F 657		

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fracture with repair" initiated on 7/8/24 included an intervention of "Resident with stage II wound to left hip. Dislikes supplements. Will offer extra 1 oz [ounce] of protein with meals to aid in wound healing" that was initiated on 12/6/24.
*A focus area of, "I use antidepressant medication (mirtazapine)" and interventions to:
-"Administer ANTIDEPRESSANT medication as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT."
-"Monitor/document/report PRN [as needed] adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL [activities of daily living] ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs [problems], movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt [weight] loss, n/v [nausea/vomiting], dry mouth, dry eyes"

7. Observation and interview on 1/14/25 at 9:20 a.m. with resident 11 revealed:
*She was admitted to the facility after she fell and broke her hip.
*She stated she was "mixed up".
*During the conversation resident 11 spoke with her eyes closed.

Review of resident 11's EMR revealed:
*She was admitted on 10/1/24.
*Her 10/7/24 BIMS assessment was 10, which indicated moderate cognitive impairment.
*Her diagnoses included: weakness, hallucinations, generalized anxiety, and dementia with psychotic disturbance.
*She was prescribed:

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F 657	Continued From page 16 -lorazepam 0.5 mg (milligrams) every four hours as needed for anxiety or restlessness. -olanzapine 5 mg two times per day related to dementia with psychotic disturbance. Review of resident 11's care plan revealed: *A focus area of, "I use psychotropic medications (olanzapine)" with interventions to: -"Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT." -"Monitor/document/report PRN adverse reactions to PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person." *Lorazepam or interventions to monitor for adverse effects was not referenced in resident 11's care plan. *Non-phamalogical interventions relating to her hallucinations, anxiety, or psychotic disturbance, was not addressed in resident 11's care plan. Interview on 1/15/25 at 3:28 p.m. with MDS/DON B revealed: *She expected staff to follow the interventions on the residents' care plans. *She was responsible for updating resident care plans. *Care plan were to be updated when there were changes in resident care. *She agreed that resident 7's care plan was not updated to include her facility-acquired pressure ulcer.	F 657		

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F 657	Continued From page 17 Interview on 1/16/25 at 8:34 a.m. with nurse manager C revealed: *She expected resident care plans to be updated to include pressure-reduction devices. *She believed that the staff knew how to access resident care plans. Interview on 1/16/25 at 10:21 a.m. with registered nurse (RN) D revealed: *She had access to view resident care plans. *She was not able to edit the care plans. *Therapy [physical and occupational] was to be initiated for residents with pressure ulcers. *If therapy placed ROHO cushions in residents' chairs they were to inform MDS/DON B to update the care plans. *Nurse manager C worked with the pharmacist on the psychotropic medications. *The charge nurse did not chart the side effects and effectiveness of the psychotropic and antidepressant medications. Review of provider's 3/2024 Care Planning Process Policy revealed: *"Using an intradisciplinary approach, each resident will have an individualized plan of care which addresses the resident's needs and severity of condition, impairment, disability, or disease and based on the universal care standards identified by the DNRC staff as the minimum standards for all residents." *"It is the responsibility of the IDT members to access the resident, individualize the plan of care, evaluate the effectiveness and the plan of care, revise the plan of care as the resident's needs change and attend care conferences." Review of the provider's undated Fall Policy	F 657		

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F 657	Continued From page 18 revealed: *"A licensed nurse will update the care plan to reflect interventions instituted to prevent further falls." *"The resident's fall will be discussed with interdisciplinary team as soon as possible after the falls to determine new interventions to try."	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to: * Implement and monitor care planned approaches for one of one sampled resident (25) identified on admission as having potential for pressure ulcer development prior to the development of a heel pressure ulcer. *Implement, monitor and accurately document skin injuries, and care plan approaches for two of two sampled residents (7 and 33) who acquired pressure ulcers after admission. Findings include:	F 686	Resident 25, 7, and 33's care plan has been updated to reflect pressure ulcer prevention interventions. Resident 25's wound has been healed. Resident 33's bottom has been healed. This deficiency has the potential to affect all residents. Lack of implementation and documentation regarding residents that require additional interventions due to the potential for development of pressure injuries. Residents at high risk for pressure injuries should have been identified and implemented on additional interventions, monitored, and accurately documented. Residents with current pressure injuries and at high risk for development of pressure injuries have been placed on frequent repositioning program or to use pressure relieving devices. All residents will be assessed of risk of pressure injuries on admission, quarterly, and with changes in conditions. Any new staging and pressuring injury residents will be referred to wound clinic. Administrator is looking at wound certification ADON. Administrator, DON, medical director, and interdisciplinary team will review and revise policies as necessary.	2/20/25

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F 686	Continued From page 19 1. Observation and interview on 1/14/25 at 10:36 a.m. with resident 25 while she was sitting in her recliner with her legs elevated revealed she: *Had been admitted to the facility on 12/23/24 for strengthening due to urinary tract infection. *Had a black spot on her left heel that was not on her heel when she was admitted. *Had edema leggings on her right leg. *Had a wound dressing to her left leg. Observation on 1/15/25 at 9:00 a.m. of resident 25's left heel revealed she had a black area to her left heel with her skin intact and no open areas. Interview on 1/16/25 8:00 a.m. with resident 25 revealed she had not started using the Prevalon boot (for pressure relief) until after she had the sore on her left heel. Interview on 1/16/25 at 8:12 a.m. with certified nursing assistant (CNA) N regarding resident 25's Prevalon boot usage revealed: *The Prevalon boot use had started when her pressure ulcer had been identified. *Resident 25 had not used a sheepskin on her to heels. Interview on 1/16/25 at 8:40 a.m. with RN D regarding resident 25's admission nursing assessment revealed she agreed that assessment did not indicate she had a pressure ulcer to her left heel on admission. Interview on 1/16/25 at 11:30 a.m. with nurse manager C regarding resident 25's interventions for pressure ulcer prevention revealed: *Prevalon boots were on the standing orders for	F 686	All necessary staff will be educated with documentation on pressure ulcer prevention of high-risk areas and pressure relieving devices by 2/20/25. Nursing staff will be educated on skin assessment expectations by 2/20/25. DON or designee will audit pressure ulcers and skin assessments once per week for 4 weeks, and monthly for 2 additional months or longer as determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	

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all residents to use for pressure ulcer prevention.
*She had not been aware that staff were not using the Prevalon boots or sheepskin for pressure ulcer prevention.
*She had been aware that staff were using the Prevalon boot since the identification of the pressure ulcer

Review of resident 25's EMR revealed:
*She had admitted to the facility on 12/23/24.
*Her brief interview for mental status (BIMS) assessment that had been completed on 1/6/25 had a score of 15 which indicated her cognition was intact.
*Her admission nursing assessment had identified inflammation (redness or swelling) to her lower back that was pink and intact.
*No documentation of any skin alteration to her left heel.
*On 1/6/25 the skin alteration had been identified.

Review of resident's Braden Score for predicting risk of pressure sore development revealed:
*On 12/23/24 and 12/30/24 her score was 16.0 indicating she was at risk.
*On 1/6/25 and 1/13/25 her score was 17.0 indicating she was at risk.

Review of resident 25's care plan initiated on 12/23/24 revealed:
*She had been identified for having the potential for pressure ulcer development.
*Prevalon boots as needed to prevent heel skin breakdown.
*Sheepskin to the end of the bed and chair for skin breakdown prevention as needed.
*Administer treatments as ordered and monitor for effectiveness.
*Resident 25's care plan had not been revised

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F 686	Continued From page 21 once her skin alteration had been identified. 2. Observation on 1/14/25 at 8:10 a.m. of resident 7's room revealed: *There was no cushion in her recliner. *She had a standard pressure reduction mattress. Observation and interview on 1/14/24 at 9:02 a.m. with resident 7 revealed: *There were two cushions in her wheelchair. *The top cushion was a waffle cushion that covered the bottom and back of the wheelchair. *The cushion under the waffle cushion was a Roho cushion (air cushion that helps distribute weight evenly to prevent pressure ulcers). *The Roho cushion was not inflated. *Resident 7 transferred herself to her recliner. *There was not a cushion in the recliner. *Resident 7 stated that her daughter brought her the waffle cushion for her "comfort". *She did not remember if she had any sores or skin problems. Interview on 1/15/25 at 3:28 p.m. with minimum data set (MDS)/director of nursing (DON) B revealed: *She was responsible for updating resident care plans. *Care plan interventions were to be updated when there were changes in resident care. *She agreed that resident 7's care plan was not updated to include her facility-acquired pressure ulcer. *It was her expectation that "someone" was checking the ROHO cushions to ensure they did not go flat. *She stated that therapy would be providing education on the ROHO cushions.	F 686		

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F 686	Continued From page 22 Interview on 1/16/25 at 8:34 a.m. with nurse manager C revealed: *It was her expectation that staff reposition residents every two hours, the cushions in the wheelchairs were properly placed, heel boots were on the residents per information provided in the electronic medical record (EMR). *MDS/DON B was responsible for updating resident care plans. *She expected resident care plans to be updated to include pressure-reduction devices. *She believed that the staff knew how to access resident care plans. *ROHO cushions were managed by therapy (physical and occupational) but it was "everyone's" responsibility to monitor the filling and maintenance of the ROHO cushions. *She did not know if staff had received training on filling and use of the ROHO cushions. Interview on 1/16/25 at 10:50 a.m. with certified nursing assistant (CNA) G revealed: *She did not have access to resident care plans. *She did not know what a ROHO cushion was. *She stated that the cushions were managed by therapy. *She was unable to identify pressure reduction interventions that were being utilized for resident 7. Review of resident 7's electronic medical record (EMR) revealed: *She was admitted on 5/30/24. *Her 12/7/24 brief interview for mental status (BIMS) assessment was 12, which indicated moderate cognitive impairment. *Her diagnoses included dementia, repeated falls, and weakness.	F 686		

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F 686	Continued From page 23 *She had had a stage II pressure ulcer (a shallow open ulcer that resulted due to pressure) on her left hip identified on 11/16/24. -The stage II pressure was documented as healed on 12/6/24. *The record lacked ongoing documentation of assessment, measurements and size of the pressure ulcer as it progressed to being healed. *Skin observation tool documentation reflected: -"Bruising" to left elbow. -"Red coccyx area noted, 2-3 small open areas noted. Fax MD [medical doctor] for tx [treatment]. Barrier cream applied. Small area noted on outer left elbow bruised with scab noted over the bony area. Area intact." Review of resident 7's 1/14/25 care plan revealed: *A focus area of "I have the potential to have impairment to skin integrity" which was initiated on 5/30/24 and updated on 6/3/24. *The use of the ROHO cushion or the waffle cushion was not included in the care plan. *A focus area of "I have a potential nutritional problem r/t [related to] hx [history] of CHF [congestive heart failure]; COPD [chronic obstructive pulmonary disease] and recent hip fracture with repair" initiated on 7/8/24 included an intervention of "Resident with stage II wound to left hip. Dislikes supplements. Will offer extra 1 oz [ounce] of protein with meals to aid in wound healing" initiated on 12/6/24. 3. Observation on 1/15/25 at 9:35 a.m. of resident 33's while in the shower room with certified nursing assistant (CNA) I revealed: *Resident 33 reported that his "butt hurt". *CNA I radioed for registered nurse (RN) D to	F 686		

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come to the shower room for a "skin check".
*When RN D came into the shower room, CNA I reported that resident 33 had sores on his "butt".
*A scabbed area was present on his left middle buttock and two open areas were present on his right middle buttock.
*RN D stated that resident 33's buttocks had open areas on them and instructed CNA I to apply a barrier cream.
*RN D indicated she would fax the doctor for orders.
*CNA I applied barrier cream to resident 33's buttocks.

Observation on 1/16/25 at 10:25 a.m. of resident 33 in the common area by the nurses' stations revealed:
*He walked with a walker.

Observation on 1/16/25 at 12:08 p.m. of resident 33's room revealed:
*There was no pressure reduction cushion on his recliner.
*His mattress was a standard pressure reduction mattress.

Interview on 1/16/25 at 10:21 a.m. with registered nurse (RN) D revealed:
*She had access to view resident care plans.
*She was not able to edit the care plans.
*She indicated ways to implement pressure reduction included:
-Repositioning the resident every two hours.
-Application of heel boots.
-An air mattress placed on the bed.
-Cushions in the residents' chairs
*Therapy was to be initiated for residents with pressure ulcers.
*The therapists were not employed by the

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F 686	Continued From page 25	F 686		

provider.
*Therapy placed the ROHO cushions in resident chairs and then notified MDS/DON B to update the care plan.
*She did not know who was responsible for monitoring and filling the ROHO cushions.
*She had not received training on the care and maintenance of the ROHO cushions.
*Wounds were monitored by the charge nurse within the treatment administration record (TAR).
*Wounds were not measured by the charge nurse.
*Wounds were measured by MDS/DON B if the resident was referred to the wound clinic.
*She did not believe that resident 33 had a cushion in his recliner in his room.
*She stated that she knew he did not have a cushion in the chair he frequently sat in in the common area by the nurses' station.

Review of resident 33's EMR revealed:
*He was admitted on 6/10/24.
*His 12/19/24 BIMS assessment was 5, which indicated severe cognitive impairment.
*His diagnoses included: diabetes, dementia with behavioral disturbance, and muscle weakness.
*He had an order for calmoseptine ointment to be applied twice daily to open areas on his buttocks that was ordered on 1/15/25.
*The 1/15/25 "Skin Observation Tool" documented a site of "Coccyx", type as "Pressure" and stage as "II". There was no documentation of size, number of open areas, specific locations, drainage, appearance of wound bed, or interventions.
*Per standard of practice there was no weekly documentation of the pressure ulcer.

Review of resident 33's 1/16/25 care plan

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F 686	Continued From page 26 revealed: *A focus area of "I have potential to have impairment to skin integrity" which was initiated on 6/10/24 and revised on 6/17/24. *The interventions for that focus area included: -"Encourage good nutrition and hydration to promote healthier skin." -"I have a pressure reduction mattress on my bed and in my wheelchair." --This intervention was initiated on 6/10/24 and revised on 6/17/24. -"Identify/document potential causative factors and eliminate/resolve where possible." Review of the provider's 8/2024 PRESSURE ULCER (PREVENTION) policy revealed: *"Resident care plans reflect any specific skin care needs." *"Protect boney prominences with cushions and pads." *"Document all wounds weekly and the pressure ulcer skin flow sheet."	F 686		
F 689 SS=E	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 observation, interview, and policy review the provider failed to ensure chemicals had not been stored under sinks in four of four	F 689	All chemicals have been removed from under the 4/4 sinks. All residents and staff have the potential to be affected if staff do not adhere to identified areas. Administrator, DON, and any others as necessary will ensure all staff responsible for chemical items have received education/training with documentation by 2/20/25. Administrator, DON, medical director, and interdisciplinary team will review and revise policies and procedures as necessary. SSD or designee will audit proper storage of chemicals 2 times weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. SSD or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	2/20/25

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F 689	Continued From page 27 rooms and were secured per their written instructions. Findings include: 1. Observation on 1/14/25 at 8:36 a.m. of the Garden Terrace hopper room revealed: *The Garden Terrace hopper room was not locked. *Under the sink was a brown wood cabinet with a lock present on the door. *The door was not locked. *This cabinet contained: -A spray bottle with a broken top labeled "75% Ethyl Alcohol". -A spray bottle labeled "C-Diff Solution Tablets". -A bottle of "Betco Kling" toilet bowl cleaner. *On the wall above the sink was a sign that said, "Keep all chemicals in LOCKED Cupboard and securely locked when not in use". 2. Observation on 1/14/25 at 9:29 a.m. of the Happy Trails hopper room revealed: *The Happy Trails hopper room was not locked. *The cupboard and under the sink was: -An aerosol spray can of Spectracide wasp and hornet killer. -An empty spray bottle with a handwritten label "PH7Q Dual disinfectant Do not throw away". -An empty bottle labeled "Isopropyl Rubbing Alcohol 70%" that was outdated on 6/17. *In a cupboard between the sink and the hopper was: -A partially full bottle of "Dermal Wound Cleanser" that did not have a resident name or date of opening on the bottle. -An aerosol bottle of "Lustre-Mist" furniture polish. 3. Observation on 1/14/25 at 1:36 p.m. of the beauty shop revealed:	F 689		

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F 689	Continued From page 28 *The beauty shop door was open. *There was a wooden cabinet beside the stationary hair dryer with a lock on it. *The cabinet was not locked. *In the cabinet was: -A spray bottle with a white label that did not have a chemical name on it. --The label was identified as a "Drug Facts Label" with the main ingredient on the label identified as "Ethyl Alcohol 75%". --The label also included "Uses: Hand sanitizer to help reduce bacteria that potentially can cause disease." --The label was dated 4/17/20. -A bottle of "Brush Delite". --The label indicated "Use rubber or plastic gloves. NEVER bare hands." -Nail polish remover that was outdated on 4/19. -A partial bottle of "BETCO" odor eliminator. *On the counter was a blue-green bottle with a clear liquid in the bottle that was one-third full. This bottle did not contain an identifier of what was in the bottle. 4. Observation on 1/15/25 at 8:43 a.m. of the shower room revealed: *The door to the shower room was not locked. *There was no staff present in the shower room. *On an over-the-bed table near the window was a spray bottle with a clear liquid that was almost empty. -Handwritten on the spray bottle was, "For reusable items combs tweezers razor parts. Use new label for each bottle of alcohol label w/ [with] exp [expiration]". The adhesive label attached to the bottle reads "Alcohol Spray 05/25". *A tall white cabinet had a padlock with a key hanging from the padlock and the door was open. *On the bottom shelf of the white cabinet was a	F 689		

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F 689	Continued From page 29 spray bottle that contained a blue liquid. -"Virex II 256 Disinfectant cleaner" was handwritten on the spray bottle. *Between the toilet and the wall was a white basin that held a toilet plunger, two toilet brushes, and a white bottle of blue liquid. -The bottle was labeled "Kling" "Toilet Cleaner" on a manufacturer's label. 5. Interview on 1/15/25 at 9:35 a.m. with certified nursing assistant (CNA) I revealed: *The shower room door was not locked. *The white cabinet was supposed to be locked when staff were not present. *The key for the cabinet was stored on the top of the cabinet. 6. Interview on 1/15/25 at 11:08 a.m. with housekeeping L revealed: *Chemicals were to be stored in a closet or storage room. *All chemicals were to be in a locked area. *Chemicals were to be stored away from residents. 7. Interview on 1/15/25 at 4:30 p.m. with minimum data set (MDS)/director of nursing (DON) B revealed: *She was unaware that the cabinet in the beauty shop was unlocked. *It was her expectation that the beauty shop cabinet was locked. *She had been told that items could not be stored under the sinks. *She confirmed there were items stored under the sinks in the hopper rooms and some were chemicals. *She was unaware that chemicals needed to be labeled with manufacturer's labels.	F 689		

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F 689	Continued From page 30 *She expected the toilet bowl cleaner to be in a locked cabinet and not accessible to the residents. 8. Interview on 1/16/25 at 8:34 a.m. with nurse manager C about chemical storage revealed: *It was her expectation that chemicals were not stored under the sink. *The provider was previously told that products could not be stored under the sink. *She believed that the cupboards under the sink had been cleaned out. *Chemicals were to be kept out of access from the residents. *Chemicals were to be stored in locked cabinets and not left unattended. *Indicated that the toilet bowl cleaner stored in the shower room beside the toilet was accessible to residents due to the door not being locked. 9. Interview on 1/16/25 at 10:50 a.m. with CNA G revealed: *She did not handle chemicals. *She stated it was the responsibility of housekeeping and maintenance. 10. Review of the provider's 2/24 Chemical Safety policy revealed: *"Promote safe use and storage of chemicals." *"Toxic items such as detergents and polishes will be properly stored, labeled, and used in a way that will not contaminate food." *This policy, presented by the provider as the chemical storage policy, referred to dietary staff and chemical use and storage related to food contamination.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3)	F 692		

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F 692	Continued From page 31 §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the provider failed to ensure one of one sampled resident (24) had been monitored for consistent weight loss. Findings include: 1. Observation on 1/15/24 from 12:00 p.m. through 12:35 p.m. of the lunch meal service revealed: *Resident 24 was seated in her wheelchair at a table. *An empty chair was between her and another resident. *Certified Nursing Assistant (CNA) G sat in the chair and assisted to resident to her left.	F 692	Resident 24's care plan has been updated to include all weight loss interventions in place. Significant resident weight loss is discussed at daily meeting among all managers. Supplement intake has been separated from all other nutritional intakes. Dietary manager educated with documentation on documentation of resident intakes by 2/20/25. Administrator, Dietician, DM, and interdisciplinary team will review and revise policies and procedures as necessary. MDS coordinator or designee will audit nutrition documentation weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. MDS coordinator or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	2/20/25

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F 692	Continued From page 32 *At 12:02 p.m. CNA Q brought her meal, and cut her burger in half, told the resident she had a cheeseburger and fries. *Resident 24 did not respond to the CNA. *At 12:06 p.m. CNA G reminded the resident that she had a burger and fries. *She made several attempts to pick up her burger and was able to take a small bite. *CNA G assisted her in eating several bites of "fruit fluff". *At 12:25 p.m. CNA G left the table and began helping other residents leave the dining room. *At 12:33 p.m. CNA H walked up to the table and said "[resident's name], are you awake?" -CNA H did not encourage her to eat or assist her with eating. *At 12:35 p.m. the resident pushed herself away from the table. -She consumed approximately one-quarter of the cheeseburger, no fries, approximately 3 oz. of fruit fluff, and 2 oz. of the red liquid which was identified by CNA G as "Boost. [supplement]" -No documentation of her consumption was made in the EMR. 2. Interview on 1/16/25 at 10:30 a.m. with CNA G revealed that resident 24 had refused breakfast. *Interview on 1/16/25 at 10:50 a.m. with Nurse Manager C revealed: *She agreed that nutrition was addressed in multiple places in the resident's care plan. -She would expect all meal consumption for resident 24 to be documented. -She was unaware that there was no documentation for many meals. _She was unaware that there was no documentation for any evening meals this month. -The residents' meal percentage consumed should be recorded by dietary staff if the resident	F 692		

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F 692	Continued From page 33 eats in the dining room and by CNA if the resident eats in their room. -The resident had been sleeping a lot in the last few months and missing a lot of meals in the dining room. *She was unaware that meal consumption was not being regularly recorded for resident 24. *The management team would meet every morning at 10:00 a.m. and discusses resident information including weight. -Weights were to be obtained weekly on bath day. -Weight loss should have been brought to the attention of the charge nurse. -She was unaware that resident 24 had flagged for weight loss on her past seven of the past weekly weights. -She stated that they had a hard time with CNAs obtaining accurate weights. 3. Review of resident 24's electronic medical record (EMR) revealed: *She was admitted to the facility on 5/8/24. -She has an indwelling catheter that was present on her admission. *She had a Brief Interview for Mental Status (BIMS) assessment score of 7 on 11/13/24, indicating severe cognitive impairment. *Was to receive a regular diet. *Her current care plan included: -She needed supervision or touching assistance by 1 staff member when eating. -A 5/8/24 initiated and 1/14/25 revised focus area that indicated she had a functional abilities performance deficit. -"EATING: I need supervision or touching assistance by 1 staff member for eating." *An initiated 5/8/24 focus area of congestive heart failure, "Encourage adequate nutrition. Offer small frequent feedings."	F 692		

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F 692	Continued From page 34 -"Monitor/document for s/sx [signs/symptoms] of malnutrition. Do not force me to eat. Offer small frequent feedings. Monitor/document food preferences." -An initiated 5/8/24, revised 5/17/24, focus area of "I have peripheral vascular disease", "Encourage good nutrition and hydration." -An initiated 5/10/24, revised 8/7/24, focus area of "I have a potential nutritional problem r/t hx (related to history] of dementia and CHF [congestive heart failure]. -Initiated 5/8/24, revised 5/17/24, focus area of "I have potential to have impairment of skin integrity", "Encourage good nutrition and hydration in order to promote healthier skin". *On 1/6/25, Registered Dietician Licensed Nutritionist (RDLN) S entered a nutrition note in the EMR that indicated: -"Weight down 5# x 1 mo. (4%)." -"down 13# x 3 mo. (10.8%)." -"down 10# x 6 mo. (8.3:%)." -"Indicates a significant weight loss over past 3 months." -"Resident is assisted with meals." -"Consider need for appetite stimulant." -"Encourage meal intake." *Resident 24's meal documentation was incomplete in the EMR (electronic medical record): -From 1/3/25 to 1/15/25, there were 39 meals served. -A total of 25 meals showed documentation. -There was no documentation of any evening meal consumed. -7 of 25 meals were marked as 0-25% of meal eaten. -Her meal consumption recorded on 1/15/2025 at 10:05 a.m. was 51-75%.	F 692		

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F 692	Continued From page 35 -According to the task list report in the EMR, the schedule for nutrition recording was every day at 09:00 a.m., 13:00 p.m., and 18:00 p.m. -The CNAs and Dietary Aides were responsible for the nutrition recording. *No hydration documentation was recorded in the EMR. -A task to record supplemental fluids was added to the EMR on 1/15/24, to be completed three times a day by a dietary aide or a CNA. *No update to the care plan had been made addressing resident's weight loss of greater that 10%.	F 692		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview the provider failed to ensure four sampled residents (11, 29, 33, and 34) had received the wrong medication administered by four of four of staff, registered nurse (RN) (D and F) and certified medication aide (CMA) (O and P). Findings include: 1. Record review of resident 33's electronic medical record (EMR) revealed: *On 12/8/2024 at 1:09 a.m. a nursing progress note had been entered that resident 33 had been given another resident's medications by CMA O. *Resident 33 was given the following medications: -Tylenol 1000 milligrams (mg) (pain reliever), -Olanzapine 5mg (antipsychotic),	F 760	All residents have the potential to be affected from this deficiency. No new med errors have been identified for resident's 11, 29, 33, and 34. Med error investigation form is in place to identify cause of medication error. All CMA/Nurses educated with documentation on disposing meds that have been DC'd by 2/20/25. 5 rights of medication education provided to all CMA's/Nurses by 2/20/25. Administrator, DON, Medical Director, and interdisciplinary team will review and revise policies and procedures as necessary. DON or designee will audit 2 med passes weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. MDS coordinator or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	2/20/25

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F 760	Continued From page 36 -Celecoxib 100mg (pain reliever). -Tamsulosin 4mg (to treat an enlarged prostate). 2. Record review of resident 34's EMR revealed: *On 9/14/24 at 5:00 p.m. resident 34 had been administered: -Carbidopa/Levodopa 25/100 mg (treat symptoms for Parkinson's disease) by CMA P. -This medication had not been ordered based on review of the physician orders. *Poison control had been notified and guided to monitor for adverse reactions including agitation and stomach pain. 3. Review of resident 11's EMR revealed: *She was not a diabetic. *On 12/13/24 at 2:30 p.m. a progress note that stated, "Resident 11 was mistaken for a different resident. At 1200 [12:00 p.m.], her blood sugar was taken and found to be 172. 7 units NovoLog insulin (a fast acting insulin) given by mistake at that time, and resident ate a good lunch. Primary MD [medical doctor] and resident's daughter were both notified. Will continue to monitor for hypoglycemia. Re-check BS [blood sugar] 1400 [2:00 p.m.] =145". *There were no further blood glucose checks documented in resident 11's EMR. *On the 12/13/24 at 1:54 p.m. fax that was sent to the provider that notified him of the medication error, the provider replied, "OK: Noted- Continue to monitor for signs of hypoglycemia [low blood sugar] for 8-12 hrs [hours] from injection." Review of the provider's 12/13/24 Medication Error Incident Audit Report for resident 11 revealed: *The Medication Error Incident Audit Report was completed by registered nurse (RN) F on	F 760		

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F 760	Continued From page 37 12/13/24 at 5:20 p.m. *"Resident 11 was mistaken for a different resident. Her blood sugar was taken and found to be 172. 7 units of NovoLog insulin given by mistake. Resident ate a good lunch." *Resident 11's "description" was documented as "Oh, okay". *The "Description of Action Taken" was, "Primary MD and resident's daughter were notified. Will Continue to monitor for hypoglycemia over the next 6-8 hours. Will recheck BS at 1400." Interview on 1/15/25 at 2:16 p.m. with nurse manager C regarding resident 11's medication error revealed: *She was not sure if education was provided or if a review of the medication error had been completed. *She stated she would have to look if there was anything completed because she was not available at the facility at the time of the medication error. Interview on 1/16/25 at 8:34 a.m. with nurse manager C about medication errors revealed: *An agency staff member made resident 11's medication error. *The company that the agency staff work for is responsible for the education and competencies of all agency staff. *Agency staff was not provided training by the provider. *When she reached out to the travel agency to request agency staff receive education on something she expected the travel agency to complete the education. *She did not follow up with the travel agency to be sure the education was completed. *She expected agency staff to work on the floor	F 760		

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F 760	Continued From page 38 on the first day of hire after being given a facility tour. 4. Review of resident 29's EMR revealed: *She was admitted on 10/26/22. *Her 7/26/24 BIMS was 12, which indicated moderate cognitive impairment. *On 12/29/24 at 2:36 p.m. an "incident/fall" progress note indicated, "This writer had just counted controlled medications with med aide today and counted Lorazepam [Ativan] for resident. Reviewed paper order in the Narcotic book and gave 1 tablet of 5mg [milligram] Lorazepam. When this nurse went to chart in the EMR, realized medication had been discontinued but not removed from the narcotic drawer of the medication cart. Contacted Nurse Manager C. Contacted resident 29's next of kin regarding medication given with no [current] order." Review of the provider's 12/30/24 Medication Error Report Sheet for resident 29 revealed: *On 12/29/24 at 1:31 p.m. RN D administered Ativan (an anti-anxiety medication) 5mg by mouth to resident 29. *The order for Ativan for resident 29 was discontinued on 11/11/24. *Steps taken to correct the error were, "Medication was removed from cart. Education provided on 5 rights of med administration. PCP [primary care provider] faxed, vitals taken". *The cause of the error was identified as "Medication was not verified in the EMAR [electronic medication administration record] prior to administration." *The action taken to prevent the error from reoccurring was, "Always use 5 rights of med administration, when medications are discontinued pull medications @that time."	F 760		

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F 760	Continued From page 39 Review of the provider's Medication Error policy revealed: *The policy was "Guidelines designed to prevent, identify, report and address errors related to administration of medications". *"The policy outlines responsibilities, steps of reporting errors, and corrective actions to be taken." *"To ensure patient safety by minimizing the risks associated with medication administration." *The procedure included: "Obtain Vital Signs", "Fax Provider. If after clinic hours or during weekend call the on-call provider.", "Create Incident in Risk Management.", and "Notify Nurse Manager/DON to initiate Medication Error Report Sheet." *The Medication Error Report Sheet included details about the medication error as well as, "Type of Medication Error", "Steps taken to correct error", "Was Physician notified", "Describe exactly what caused error to occur", and "Actions taken to prevent error from reoccurring".	F 760		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(p)(1)-(5) §483.70(p) 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(p)(1) Direct Care Staff.	F 851	Unable to correct prior noncompliance of Payroll Based Journal Submission accuracy. Staff was present on inaccurately reported days. PBJ reporter educated with documentation on PBJ reporting by 2/20/25. Administrator will audit correct reporting of Payroll Based Journal quarterly for 2 quarters. Administrator will report findings at monthly QAPI meetings until audit is complete and no longer needs to be assessed.	2/20/25

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F 851	Continued From page 40 Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and 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(p)(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(p)(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(p)(4) Data format. The facility must submit direct care staffing	F 851		

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F 851	Continued From page 41 information in the uniform format specified by CMS. §483.70(p)(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 Payroll Based Journal (PBJ) record review, employee timecard review, staffing schedules, and electronic medical record (EMR) review, the provider failed to submit PBJ data accurately for one of one federal fiscal quarter (Quarter 4, 2024). Findings include: 1. Review of PBJ records submitted to the Center for Medicaid and Medicare Service (CMS) revealed the provider submitted no licensed nursing coverage 24 hours per day for quarter 4, 2024: 9/15/24, 9/17/24, 9/19/24, and 9/21/24. Review of the provider's employee timecards, staffing schedules, and residents' EMR records documentation revealed the provider had licensed nursing coverage 24 hours per day for the period referenced above. Interview on 1/15/25 at 3:03 p.m. with administrator A and nurse manager C revealed: *Nurse manager C made the nursing schedule. *She did not participate in PBJ submission. *Administrator A submitted the records to PBJ. *The information was automatically obtained from the individual staff timecards by their electronic payroll system. *She entered the agency staff manually. *She was not aware the PBJ reports indicated the provider did not have licensed nursing coverage	F 851		

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F 851	Continued From page 42 24 hours per day in quarter 4, 2024. *She did not know where to find the PBJ reports. *She thought the missed information could have been due to her manually entering agency staff hours. *She reviewed the September 2024 nurse schedule and indicated that some of the days of missing coverage in the report were not staffed by agency staff. *She did not know how the hours were incorrectly reported to PBJ.	F 851	Proper PPE and EBP signs for all necessary residents has been set up in resident rooms.All resident care items have been covered. All chemicals and expired items have been removed from under the hopper sinks, beauty room, and shower room. All residents and staff have the potential to be affected if staff do not adhere to identified areas. Hand sanitizer dispensers have been put up outside hopper rooms. Administrator, DON, Infection control nurse, and/or designee in collaboration with medical director will review and revise necessary policies and procedures for EBP, hand hygiene, and disposing of resident care items. DON or designee will provide education with documentation to all staff about Enhanced Barrier Precautions, hand hygiene, disposing of resident care items. DON or designee will audit hand hygiene, EBP PPE, and proper storage and disposal or resident care items weekly for 4 weeks and monthly for 2 months or longer as determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	
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 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 §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		2/20/25

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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.

§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

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IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review the provider failed to:
*Accurately identify and implement enhanced barrier precautions (EBP) for three of three sampled residents (4, 20, and 24) who had care concerns requiring personal protective equipment (PPE).
*Utilize appropriate hand hygiene and gloves during cares by one of one staff (certified nursing assistant (CNA) I with one of one resident (33).
*Appropriately maintain and dispose of resident care items in two of two hopper rooms, one of one shower room, and one of one beauty shop.
Findings include:

1. Observation on 1/14/25 at 8:15 a.m. of the Garden Terrace hallway revealed there was no PPE in the hallway or residents' rooms.

Observation on 1/14/25 at 9:09 a.m. of resident 4 in the dining room revealed:
*She was seated in her wheelchair.
*She had her right lower extremity (RLE) wrapped in a dressing.
*She was touching what appeared to be a wound on her RLE that was not covered and was open and red.

2. Observation on 1/14/25 at 9:36 a.m. of resident 4's room revealed:
*There was no sign indicating a need for EBP.
*There was no personal protective equipment (PPE) outside or inside her room.
*She shared a room with resident 9.
*The room and an adjoining bathroom with the room next door.

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F 880	Continued From page 45 Review of resident 4's electronic medical record (EMR) revealed: *She was admitted on 5/23/24 *She had a Brief Interview of Mental Status (BIMS) assessment score of 8, which indicated she was moderately cognitively impaired. *Her diagnoses included cellulitis, dementia, and bulbous pemphigoid (autoimmune disease that causes skin blisters) *She had an order for wound care to her RLE. *She was not on enhanced barrier precautions. Interview on 1/15/25 at 9:22 a.m. with registered nurse (RN) D regarding how she performed resident 4's RLE dressing change revealed: *She performed hand hygiene before putting on gloves. *She removed the dirty wound dressing and threw it away in the garbage can. *She performed hand hygiene before putting on a clean pair of gloves. *She applied clean dressings to the wound. *She confirmed she would only wear gloves for PPE for resident 4's dressing change of her wound. Interview on 1/15/25 at 12:09 p.m. with minimum data set (MDS)/ director of nursing (DON) regarding their enhanced barrier precautions (EBP) protocol revealed: *She believed the statement in the policy that read, "CMS [Center for Medicare and Medicaid Services] notes facilities have some discretion when implementing EBP and balancing the need to maintain a homelike environment for residents" came from the CDC (Center for Disease Control) website. *She did not produce where that portion of the	F 880		

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F 880	Continued From page 46 policy was referenced from as requested. Interview on 1/16/25 at 10:21 a.m. with RN D about EBP revealed: *Anyone with a urinary catheter was on EBP. -She listed three residents who had a urinary catheter. *She indicated that residents who had MRSA (methicillin-resistant Staphylococcus aureus) or VRE (Vancomycin resistant enterococcus) would also be on EBP. -There were no residents in the facility that currently had either of these. 3. Observation on 1/14/25 at 8:15 a.m. of Garden Terrace hallway revealed: *There was one wall hanging alcohol-based hand sanitizer (ABHS) in the hallway. -It was in the middle of the hallway. *Each resident room had a wall hanging ABHS near the bathroom door. 4. Observation on 1/14/25 at 8:36 a.m. of the Garden Terrace hopper room revealed: *The cabinet under the sink contained: -A spray bottle labeled 75% Ethyl Alcohol with a broken spray top. -A spray bottle labeled "C-Diff [clostridium difficile] solution tablets. -Multiple glass containers. -A plastic basin. -Empty plastic ice cream buckets. -A short white extension cord. -A bottle of toilet bowl clearer with a brush in a plastic white bucket. The bottom of the bucket had multiple black flecks of an unknown substance and a yellow crusty unknown substance. *There was no ABHS available in or outside the	F 880		

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door of the hopper room.
*Soap and water were available at the sink.
*Two unidentified staff opened the door, threw trash in the garbage and exited the room without washing their hands.

5. Observation on 1/14/25 at 8:56 a.m. in Garden Terrace hallway revealed:
*A covered cart was parked in the hallway.
*On top of the cart were two fabric soaker pads and a bed sheet.
*The linen was not covered.
*There were two full body mechanical lifts parked in the hallway.
*Neither lift had a container of disinfectant wipes.

6. Observation on 1/14/25 at 9:29 a.m. of the Happy Trails hopper room revealed:
*There was no ABHS available in or outside the door of the hopper room.
*Soap and water were available at the sink.
*The cabinet under the sink contained:
-One teal plastic bedpan and two gray plastic bed pans.
-A can of Spectracide wasp and hornet killer.
-A white basin.
-Two plastic buckets.
-A clear Sterlite four-quart plastic container with brown paper towels. On top of the paper towels was a rectangular silver metal cover with green corrosion on it. Inside the clear container along the paper towels was cobwebs and brown flakes of an unknown substance.
-An empty spray bottle labeled "PH7Q Dual disinfectant".
-A partial bottle of "tearless Shampoo & Body Wash".
-An open container of "Super Sani-Cloths".
- Two round pink basins.

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F 880	Continued From page 48 -Two bundles of brown paper towels and two rolls of toilet paper. -An empty bottle labeled Isopropyl Rubbing Alcohol 70% that had outdated on 6/17. *The cabinet between the hopper and the sink contained: -A partial bottle of "Dermal Wound Cleanser" that was outdated on 4/22. -A partial bottle of hand sanitizer that was outdated on 8/22. -A cardboard box that contained red bags with moisture damage present to the box. *Two unidentified individuals opened the door, threw garbage into the hamper and did not wash their hands. 7. Observation on 1/14/25 at 1:36 p.m. of the beauty shop revealed: *A wooden cabinet around the stationary hair dryer. *The wooden cabinet contained: -A partial bottle of hand sanitizer that was expired on 7/22. -Nail polish remover that was expired on 4/19. -A bottle of Tresemme conditioner that had a name on it that was not a current resident. -A partial container of disinfectant wipes that was expired on 2/21. *The counter beside the hair washing sink contained: -A dry container of disinfectant wipes. -A bottle of ABHS that was outdated on 9/23. -A bottle of Biolage Antidandruff shampoo that was outdated on 10/24. -A white bucket that contained hair curlers with no resident identifier on the bucket. -The curlers contained strands of gray and white hair. -A clear container of pins to secure the curlers	F 880		

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with no resident identifier.
*The filter on the back of the stationary hair dryer had a thick coating of dust and gray and tan particles.

Interview on 1/14/25 at 1:56 p.m. with RN D revealed:
*Staff use the beauty shop for the residents.
*Bath aides use the curlers to set residents' hair.
*Local beauticians use the beauty shop to cut residents' hair.

8. Observation on 1/15/25 at 8:43 a.m. of the shower room revealed:
*There were tiles missing on the shower floor.
*In a plastic three-drawer cabinet were:
-Two electric razors that were filled with white and gray hair.
-Two different sized curling irons with an unknown crusted white substance and long white hairs on the barrels.
*On the floor near the sink were two blue squares of non-stick rubber-like material that had hairs and other unknown white particles on them.
*On the wooden shelves between the cabinet and the sink there were:
-Multiple bags of open incontinent products without any resident identifiers.
-An open container of disposable skin wipes with an unknown brown substance on the container.
--There was no resident identifier on the container.
-Twelve uncovered towels.
-A gray basin with black garbage bags and two unrolled gait belts with a brown substance on one of the gait belts.
*On the outside of the white cabinet was a piece of paper titled "Bath Aide".
-A list of the bath aide duties was on the piece of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 50 paper. -Under the duties there was a portion labeled "Infection Control". --"Use 1/3 cup or less Virex Cleaner in spray bottle fill with water. Spray down shower chair/bath in between resident use." --"Use alcohol spray for all other reusable items between uses. Combs Nail clippers Tweezers Shave Parts". *A towel was covering an over-the-bed table by the window. *On the towel was a plastic gray basin that contained two black electric razors filled with gray hair, a temporal thermometer (thermometer that takes temperature on the forehead), a wrist blood pressure cuff, and a white coffee cup. *The coffee cup contained: -Eight pens, two black combs, one purple pick, one silver scissors, one black handles scissors, two nail clippers, a spray bottle with a handwritten label "For reusable items combs tweezers, razor parts. Alcohol Spray 05/25", and a bottle of alcohol-based hand sanitizer (ABHS). *A towel was covering an over-the-bed table near the shower. *On the towel was five wash cloths and two pump bottles labeled conditioner and shampoo and body wash. 9. Observation and interview on 1/15/25 at 9:09 a.m. of CNA I as she removed hair rollers from a resident in the beauty shop revealed: *She removed the rollers from the resident's hair and placed them in a white bucket with other rollers. *She did not clean the rollers, or the pins used to hold the rollers in place. *She stated that this was the only resident she set hair for.	F 880		

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F 880	Continued From page 51 *She had not been trained on the use of rollers or how to clean them. *She reused the rollers and pins without them being cleaned. 10. Observation and interview on 1/15/25 at 9:35 a.m. of CNA I during a resident shower revealed: *Applied gloves without prior hand hygiene. *She undressed the resident. *Took the resident's blood pressure and temperature and did not cleanse the equipment after use. *Shaved the resident's face with the electric razor from the over-the-bed table. *Sprayed the outside of the razor with the bottle labeled alcohol with three sprays and placed it on a paper towel. *She did not empty the facial hair from the razor. *Pushed the resident on the shower chair into the shower and pumped the shampoo and body wash into a washcloth she removed from the over-the-bed table near the shower. *After the shower she used a towel from the wooden shelves to dry off the resident. *She changed gloves without hand hygiene. *She placed the two blue squares of non-stick rubber-like material under the resident's bare feet for the resident to stand on while she observed and dried his skin. *She used a pump lotion bottle, without a resident identifier on it, multiple times to dispense lotion and apply it on the resident. *Used spray deodorant and dressed the resident. *She changed her gloves without performing hand hygiene. *She assisted the resident in putting on his clothing. *Cleaned under the resident's fingernails with a wood stick.	F 880		

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F 880	Continued From page 52 *Applied after shave, without a resident identifier on it, to the resident. *Changed her gloves without performing hand hygiene. *Applied skin protectant cream to the resident's buttocks from a tube that was dated 7/20/24 with no resident identifier on it. *She removed her gloves without performing hand hygiene. *She placed the aftershave, skin protectant cream, and deodorant into the white cabinet without disinfecting after resident use. *She did not disinfect the lotion after use and left it on the over-the-bed table. *She stated that some residents have their own products, but others used shared products. *The shared products should be wiped with a disinfectant wipe after each resident's use. *The end of the razor was sprayed with the alcohol after each use and the razors were emptied at the end of the day. *Nail clippers and combs were also sprayed with alcohol after each resident use. *She sprayed the shower chair with the bottle labeled Virex. *She did not spray the floor or the walls of the shower. *She indicated she would let the chair sit for "a couple minutes". *She washed her hands with soap and water. 11. Interview on 1/15/25 at 4:30 p.m. with MDS/DON B revealed: *She was unaware there was outdated products in the beauty shop and both hopper rooms. *She was unaware there was a filter in the back of the stationary hair dryer that needed to be cleaned. *She did not know how the hair rollers were	F 880		

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F 880	Continued From page 53 supposed to be cleaned. *She stated the provider had been told during a previous survey that items could not be stored under the sink, and she thought the items had been removed. *She was unaware how the nail clippers, razors, and combs were being cleaned. *She verified the electric razors in the shower room had not been emptied and were filled with white and gray hair. *She did not know the linen in the shower room needed to be covered. *It was her expectation staff performed hand hygiene after bringing soiled materials into the hopper rooms. *It was her expectation that hand hygiene be performed prior to applying gloves and after removing gloves. 12. Interview on 1/15/25 at 5:00 p.m. with administrator A revealed: *The provider did not have a policy for cleaning of hair rollers, nail clippers, and hair combs. *The provider did not have a policy on expired products. 13. Interview on 1/16/25 at 8:34 a.m. with nurse manager C revealed: *Razors should be cleaned between each resident, per facility policy. *She did not know how the razors were currently being cleaned. *She expected that the facial hair be brushed out, the parts were taken out, and the parts were sprayed with alcohol. *She thought the instructions were on the rubbing alcohol bottle that told staff haw to mix the spray bottle, but the manufacturer's instructions were to be followed when mixing.	F 880		

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F 880	Continued From page 54 *She believed that environmental service manager J had told the nursing staff the process of dilution. *Linen should be covered when in the hallway and the towels in the shower room be in a covered cart. *Nothing was to be stored under the sinks. *There was not a person assigned to check outdates. *She felt that there should be someone responsible for this. 14. Interview on 1/16/25 at 9:09 a.m. with environmental service manager J revealed: *She had not provided training to the nursing staff about mixing chemicals. *She was not aware that nursing staff was using alcohol. Interview on 1/16/25 at 10:21 a.m. with RN D regarding expired products revealed: *She was not sure who oversaw checking for expired products. *She checked the expiration dates of products as she used them. *She indicated that nurse manager C completed audits of the medication carts for expired medications and products. 15. Observation and interview on 1/15/25 at 9:41 a.m. with CNA G regarding resident 20 and enhanced barrier precautions (EBP) revealed: *There was a small magnetic sign on the top of the door frame titled EBP. *CNA G entered resident 20's room and sanitized her hands. -Put gloves on. -Put paper towels on the floor as a barrier. -Put a plastic cylinder on the paper towels. -Emptied the urine from the catheter bag into the cylinder.	F 880		

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F 880	Continued From page 55 -Emptied the container of urine into the toilet. -Rinsed the cylinder in the sink and emptied it into the toilet. -Put the cylinder back on a shelf. -Removed her gloves and sanitized her hands. *She confirmed this was how she normally emptied catheter bags. *She was not sure what the EBP sign at the top of the door frame meant. Review of resident 20's electronic medical record (EMR) regarding her catheter revealed: *She had an order for a suprapubic catheter due to urine retention. *Her revised 7/1/24 care plan directed staff to: -Check tubing for kinks each shift. -Encourage fluid intake. -Monitor and document output as per facility policy. -Monitor/document for pain/discomfort due to catheter. *She was dependent on one staff for toileting. *The care plan had no guidance for enhanced barrier precautions. 16. Interview on 1/14/25 at 3:50 p.m. with certified nursing assistant (CNA) H regarding enhanced barrier precautions revealed he had been unsure what that had been and asked other nurses to help him. Interview on 1/14/25 at 3:25 p.m. with Minimum Data Set (MDS)/ director of nursing (DON)/ infection preventionist (IP) B regarding enhanced barrier precaution revealed: *It had been used for wounds, catheters, and anything that could transmit bacteria. *PPE had been stored in the medication storage room. *It would have been the facility's discretion if PPE	F 880		

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F 880	Continued From page 56 was required with enhanced barrier precautions. Interview on 1/15/25 at 2:00 p.m. with medical director U regarding residents placed on enhanced barrier precautions and urinalysis collection revealed: *He had not been aware of enhanced barrier precautions and the criteria for residents to place on precautions. *He would not want residents to be isolated if there were on precautions. *If a resident has had multiple urinary tract infection, he would prefer a catheter urinalysis to be collected. *He would prefer more infection symptoms to be exhibited by the resident before a u/a is collected. *He does participate in the antibiotic stewardship and other providers have access to the facilities program. 17. Observation on 1/14/25 at 1:40 p.m. revealed a 1.5 x 3 inch magnet with EBP written on it stuck to the top of the door frame to resident 24's room. -No personal protective equipment (PPE) was present in the hall or in resident 24's room. Interview on 1/14/25 at 1:57 p.m. with certified nursing aide (CNA) Q revealed: -She wasn't sure what the EBP tag meant. -She thought it had something to do with the floor mat. -She stated "I should know since I get her up". -She went to the nurse's station and returned, saying that the EBP had to do with blood sugars. -She did not know what enhanced barrier precautions meant. -She did not wear any PPE when working with resident 24. Record review on 1/14/25 revealed resident 24	F 880		

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F 880	Continued From page 57 had an indwelling catheter since prior to admission on 5/8/24. -The care plan had no guidance for enhanced barrier precautions. Review of the provider's 6/23/23 Cleaning of Durable Medical and Therapy Equipment policy revealed: *"To provide residents with clean, sanitary equipment and prevent the spread of infection." *The policy did not address items such as thermometers or blood pressure cuffs. Review of the provider's Hand Hygiene policy revealed: *"Cleaning hands promptly and thoroughly between resident contact and after contact with blood, body fluids, secretions, excretions, equipment and potentially contaminated surfaces is an important strategy for preventing healthcare associated infections." "Hand hygiene should be performed:" "After removing gloves", After handling equipment supplies, or linen contaminated with body substances", and "When moving from contaminated to clean body sites". Review of the provider's Infection Control and Prevention policy revealed: *"Using Standard and Transmission based Precautions appropriately and correctly, you will keep yourself and your residents safe from acquiring infection while in the healthcare setting." *Standard Precautions include "Hand washing single most effective way to prevent the transmission of disease". Review of the provider's April 2024 Enhanced	F 880		

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F 880	Continued From page 58 Barrier Precautions policy revealed: *"It is a policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms (MDRO)." *"Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDROs) in nursing homes. Enhanced barrier precautions involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisitions (e,g ,residents with wounds or indwelling medical devices)."	F 880		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review the provider failed to adequately implement and monitor an effective antibiotic stewardship program. Findings include: 1. Observation and interview on 1/14/25 at 8:26 a.m. of resident 10 in room 116 revealed: *She was sitting in her recliner working with an	F 881	Accurate SBAR form has been provided at nurse's station. Administrator, DON, medical director, and interdisciplinary team will review and revise policies as necessary. DON or designee will provide education with documentation to all nurses about SBAR form and non-pharmacological interventions for UTI prevention along with any policy and procedure updates. DON or designee will audit SBAR form sheets and ongoing infections weekly for 4 weeks and monthly for 2 months or longer determined by audit results. DON or designee will report findings at monthly QAPI meetings until audit is complete and issue no longer needs to be addressed.	2/20/25

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F 881	Continued From page 59 occupational therapist. *Her goal was to get stronger and go to assisted living. *She had been in the hospital recently for an infection. Review of resident 10's EMR revealed: *She was admitted on 3/6/24. *Her diagnoses were: -Chronic kidney disease, stage four. -Type two diabetes mellitus without complications. -Retention of urine, unspecified. -History of urinary tract infection. *Her 1/14/25 revised care plan had an intervention to monitor for signs and symptoms of infection, UTI (urinary tract infection) initiated on 3/27/24. *She had orders for antibiotics to treat a UTI on 8/20/24, 8/21/24, 9/9/24, 10/21/24, 11/19/24, 12/6/24, and 12/16/24. Interview on 1/15/25 at 3:29 p.m. with minimum data set (MDS)/director of nursing (DON) B revealed: *She is the infection preventionist. *She presented a spreadsheet of the infections in the facility as her antibiotic stewardship tracking. *She stated that the infections each month are discussed at QAPI (quality assurance and performance improvement). *A PIP (performance improvement plan) has been developed related to urinary tract infections in the facility. *Management was auditing resident fluid intake, staff rounding on residents every two hours, and wiping from front to back when staff was performing genital hygiene. *Management had done hand hygiene audits in	F 881		

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F 881	Continued From page 60 the past. *Staff was not obtaining an order each time a urine dip was completed. *It was her expectation that staff document the reason for completing a urine dip or getting a UA. *She expected a nurse's note to be entered into the resident's EMR that indicated what the staff was doing and why. *She did not believe that staff were using a form, such as a SBAR (situation, background, assessment, recommendation) to determine if a urine dip or UA is indicated. *She believed that there was an SBAR form available on the computer. -The SBAR form she located was for "Skin/Soft Tissue". *She indicated she believed a form such as an SBAR form would be helpful in the decision-making process for the nurses. *She is responsible for follow-up of UA and urine culture (UC) results. *After the urine culture is resulted, she waits for the provider to either write an order to continue the antibiotic or stop the antibiotic. *Lab sends the results of the UA and UC to the facility and the results are scanned into the resident EMR. *She was unable to locate a UC result in resident 11's EMR for a UTI diagnosis and treatment on 1/16/24. *The provider does not get results of chest x-rays when residents go to the clinic and are diagnosed with pneumonia. Interview on 1/16/25 at 10:05 a.m. with CNA G regarding resident 10's chronic UTIs revealed: *She had been instructed to watch for changes in her behavior that would indicate a UTI. *She would report any changes to the charge	F 881		

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F 881	Continued From page 61	F 881		

nurse.
*If a UTI was suspected they would put a hat in her toilet to collect a urine sample.

Interview on 1/16/25 at 10:21 a.m. with registered nurse (RN) D revealed:
*If the nurse suspected a resident had a urinary tract infection (UTI) the nurse would complete a urine dip test.
*If the urine dip was positive the primary care provider would be faxed with the resident's signs and symptoms and a request to collect a urine sample for a urinalysis.
*The urine would then be sent to lab for evaluation.
*The lab would send the results of the urinalysis to the facility and the primary care provider would decide if treatment was necessary.
*An order for the urine dip was not obtained prior to completing the urine dip test.
*She was under the understanding since she was hired that there was an "understanding" with medical director U that a urine dip test could be performed with any signs and symptoms of a UTI.
*Symptoms she would consider to be signs of a UTI included: urine with a strong odor, frequency of urination, pain, burning with urination, and with "certain residents" behavior changes.
*She did not enter a progress note in a resident's chart if she completed a urine dip test or the reasoning the urine dip test was completed.
*She would enter a progress note in the resident's chart when she faxed for the UA, the results are returned, and when the family was notified of the treatment.
*When asked about documentation of the urinalysis completed on resident 11 in January 2025. RN D stated she was asked by resident 11's family to contact hospice to obtain a UA

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F 881	Continued From page 62 order. She agreed there was no documentation in the resident's chart that indicated the family requested the UA and any communication with hospice or the reason the UA was requested by family. Review of resident 11's hospice note revealed a UA was being obtained by SNF (skilled nursing facility) for symptoms if a UTI. Review of the Infection Prevention spread sheets revealed: *There were five UTIs (four residents) and two cellulitis (skin infection) (one resident) treated in August 2024. *There were seven UTIs (five residents) treated in September 2024. *There were six UTIs (four residents) and two cellulitis treated in October 2024. *There were two UTIs, two cellulitis, and two respiratory infections treated in November 2024. *There were three UTIs, and four pneumonias (three residents) treated in December 2024. *From August through December there were six residents that were prescribed antibiotics more than one time. Review of the provider's 2024 Infection Control and Prevention policy revealed: *The infection preventionist is responsible for "Systemic data collection to identify, trend and track infection in residents". *"The facility will work to optimize the treatment of infections while reducing the adverse events associated with antibiotic use". *"Antibiotic use will be tracked and reported monthly". -"Number of resident prescribed antibiotics". -"Number and type of infections---trends and outbreak control if applicable".	F 881		

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F 881	Continued From page 63 -"Number of lab proof of infections versus those without". -"Number of residents with C. [Clostridium] Difficile, antibiotic resistant organisms or adverse drug events".	F 881		

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	435129	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/14/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELLS NURSING AND REHAB CENTER INC	**1400 THRESHER DR** **DELL RAPIDS, SD 57022**

(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
K 000	INITIAL COMMENTS A recertification survey was conducted on 1/14/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Dells Nursing and Rehab Inc was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/14/25. Please mark an F in the completion date column for the K241 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K522 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observation and document review, the provider failed to maintain at least two conforming	K 241		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Togel
TITLE: Administrator
(X6) DATE: 2/10/25

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 241	Continued From page 1 exits from each floor level of the building. The basement had only one conforming exit. Findings include: 1. Observation on 1/14/25 at 11:38 a.m. revealed the basement had only one conforming exit directly to the exterior of the building. The second egress routes were through hazardous areas of the boiler and laundry rooms to an area equipped with a fixed ladder. Review of previous survey data confirmed that the condition existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. This deficiency would not affect any of the residents and minimal staff within the facility.	K 241		
K 522 SS=D	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the provider failed to maintain combustion	K 522	Maintenance director added combustion airway to laundry room immediately. Administrator will educate maintenance director on combustion air by 2/20/25. Maintenance director or designee will audit adequate combustion airways weekly for 4 weeks and monthly for 2 months. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	2/20/25

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K 522	Continued From page 2 (fresh) air in one randomly observed area (laundry). Findings include: 1. Observation of the two commercial natural gas-fired dryers in the laundry room on 1/14/25 at 11:42 a.m. revealed the following: a. There was a dedicated combustion (fresh) air ductwork provided for the operation of the natural gas-fired commercial clothes dryers with a pneumatic operator for the damper at the discharge end of the fresh air duct. The pneumatic operator did not function, and the damper was in the closed position. A damper for the required combustion fresh air supply must automatically open upon operation of either of the two gas-fired dryers. b. The corridor door to the laundry room may not be used as a source of combustion air for the dryers. This door is to be closed at all times to maintain fire separation of the laundry room. Interview with the maintenance supervisor at the time of the observations confirmed that finding. Record review of the federal survey conducted on 8/6/2024 revealed that pneumatic operator and damper had been previously identified as not compliant with the requirements for combustion air. The deficiency affected one of several requirements for fuel-fired devices.	K 522		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 1/14/24. Dells Nursing and Rehab Center Inc was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Calyn Togel	Administrator	2/10/2025

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	10613	A. BUILDING: _____ B. WING _____	01/16/2025

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DELLS NURSING AND REHAB CENTER INC	1400 THRESHER DR DELL RAPIDS, SD 57022

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S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/14/25 through 1/16/25. Dells Nursing and Rehab Center Inc. was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation A facility shall provide electrically powered exhaust ventilation in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in three randomly observed rooms (toilet room for resident room 121, west wing tub room, and west wing hopper room). Findings include: 1. Observation on 1/14/24 at 2:10 p.m. revealed the exhaust ventilation for the toilet room of resident room 121 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance director at that same time confirmed that finding. He stated he was unaware the building's exhaust was not working in that location. That room was required to have exhaust ventilation directed to the exterior of the building. 2. Observation on 1/14/24 at 2:49 p.m. revealed	S 157	Maintenance director fixed exhaust ventilation in toilet room for resident room 121, west wing tub room, and west wing hopper room. Administrator will educate maintenance director on maintaining exhaust ventilation by 2/20/25. Maintenance director or designee will audit 2 random rooms for proper exhaust ventilation weekly for 4 weeks and monthly for 2 months. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	2/20/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Calyn Togel
TITLE: Administrator
(X6) DATE: 2/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 157	Continued From page 1 the exhaust ventilation for the west wing tub room was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance director at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. That room was required to have exhaust ventilation directed to the exterior of the building. 3. Observation on 1/14/24 at 2:54 p.m. revealed the exhaust ventilation for the west wing hopper room was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance director at that same time confirmed that finding. He revealed he was unaware why the exhaust ventilation was not working at that location. He further added he thought the rooftop exhaust fan that served that room, and the adjacent tub room might have had lost the belt or had the belt slip off recently. He also added the exhaust fan for that location served most of the west wing. That room was required to have exhaust ventilation directed to the exterior of the building.	S 157		