DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	C 10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/27/22 through 9/30/22, and on 10/3/22 through 10/4/22. Avantara Norton was found not in compliance with the following requirements: F574, F584, F600, F656, F658, F677, F684, F686, F689, F692, F725, F755, F809, F812, F838, 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 9/27/22 through 9/30/22, and on 10/3/22 through 10/4/22. Areas surveyed included quality of care and quality of life. Avantara Norton was found not in compliance with the following requirements: F584, F600, F656, F677, F684, F686, F689, F692, F725, F809, and F838. On 9/30/22 at 11:15 a.m., immediate jeopardy was identified related to maintaining proper hydration and health at F692. At 12:35 p.m., administrator A, director of nursing B, and regional nurse consultant X provided a plan for removal of the immediate jeopardy. At 1:21 p.m., the removal plan was accepted with agreed upon changes made by the provider. The survey team exited the building at 1:30 p.m. On 10/3/22 at 12:45 p.m., the survey team reviewed the provider's documentation for removal of the immediate jeopardy. Immediacy was removed at 2:57 p.m., after the provider took additional actions to complete the removal plan. The resident census was 79.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nickel	LNHA	10/22/22

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

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F 574 SS=E	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State	F 574	1. Residents 9, 34, 36, 50, 52, 63, and 73 were all advised of the right to file a complaint and the locations of the South Dakota Department of Health (SD DOH) poster listing the phone number. 2. All residents are at risk of being affected by the facility's failure to display the SD DOH complaint phone number in a prominent place. 3. The Administrator or designee will educate all staff on the newly created policy of Required Notices and Contact Information and the requirement to have number SD DOH complaint phone number posted in a prominent location. Education will occur no later than November 2, 2022 and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated upon their return prior to their first shift worked. 4. The Administrator or designee will interview five random residents to ensure that the residents are aware of their right to file a complaint and are aware of the required posting location and that the posting is posted. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the Administrator at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	11/2/22

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F 574	Continued From page 2 and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the provider failed to ensure seven residents (9, 34, 36, 50, 52, 63, and 73) had information about how to file complaints with the state survey agency. Findings include: 1. During a resident group interview on 9/29/22 at 10:00 a.m. with residents 9, 34, 36, 50, 52, 63, and 73 revealed: *All of them, except resident 9, identified	F 574		

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F 574	Continued From page 3	F 574		

themselves as being regular attendees of the monthly resident council meetings.
*They voiced numerous concerns about:
-Being told during resident council meetings that concerns from the previous meeting were addressed but what they experience demonstrated that "they really aren't."
-There "have been so many changes in the last two months" that they do not know who to go to when reporting a grievance.
-Staff have treated them differently after reporting a concern. Residents 9, 34, 36, 63, and 73 provided examples of specific situations and commented, "This should be our home, but it isn't," and "They treat us as just a reason to get a paycheck."
-Staffing is "not enough," "Wait too long for call lights to be answered," staff get pulled away during the provision of care, "sometimes several times," to help with other situations, and the certified nursing assistants (CNAs) have been seen standing at the desk or in the hallway talking and laughing with each other while call lights are going off. That had been "reported to the nurse but there have been no changes."
-Fresh water was not routinely delivered but provided if requested and they had never seen a snack cart.
-Saturday mail was sometimes not delivered until Sunday because the activity director was the only one that delivered the mail.
*They were not aware of the right nor the location of the posted phone number for filing a complaint with the South Dakota Department of Health (SD DOH) complaint department.

Observations throughout the facility on 9/29/22 between 12:30 p.m. and 4:00 p.m. did not reveal a notice of the resident's right to contact the SD

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F 574	Continued From page 4 DOH with the phone number listed. Interview on 9/29/22 at 4:34 p.m. with social services designee D revealed she would: *Address the grievance process during the next Resident Council meeting, *Ensure a SD DOH complaint poster gets hung up where residents can find it. *Have a discussion of rights during each future monthly meeting. *Address delivery of personal mail on Saturdays.	F 574		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584	1. The following cleaning and repairs have been made: Resident 12's miniblind and bedside table were replaced, and his wheelchair was cleaned and the cracked arms were replaced. Resident 46's bedside table was cleaned. The east shower room was thoroughly cleaned and organized and the shower ceiling repainted, the rusted wire rack removed, the fan cleaned, and the shelving in the wooden cupboard shelves was replaced to ensure they are cleanable. Resident 14's wheelchair was cleaned. The mechanical lift was cleaned and a plastic covering the base leg was ordered to replace the missing piece. Resident 20's doorway was cleaned and a threshold installed. Resident 51's bathroom floor has been repaired and the toilet cleaned. The sit to stand lift has been cleaned. Resident 45's room has been cleaned and ointments, creams and powder stored properly. Resident 3's television was safely secured. The bathroom between rooms 225 and 226 has been cleaned. Residents 8, 17, 24, 43, 53, 60, 277, 278 wall has been repaired/painted. Resident 49's miniblind has been replaced.	11/2/22

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F 584	Continued From page 5 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to have a system to ensure a safe, sanitary, and homelike environment was maintained for: *Two of two randomly observed resident (5 and 12) wheelchairs with cracked armrests. *Two of two randomly observed resident (12 and 14) wheelchairs were covered in dust and other particles. *Fifteen of fifteen randomly observed resident (3, 8, 12, 17, 20, 24, 43, 45, 46, 49, 51, 53, 60, 277, and 278) rooms were in good repair. *One of one randomly observed resident room (11) with a television unsafely placed on a bedside dresser. *Two of two mechanical lifts on the East wing. *Two of two resident bathing rooms. *Stains on the carpet outside of room 114. Findings include: 1. Observation on 9/27/22 at 10:46 a.m. of resident 12 in his room revealed:	F 584	Resident 5's wheelchair arms have been replaced. Resident 24's bed sheets were replaced and linens have been inspected to ensure they are not overly worn; Residents 53 and 278's rubber floorboard was secured to the wall and the spider web on the outside of the window was removed. The stains on the carpet outside room 114 have been cleaned, however, the stains still persist. A vendor will be contracted to replace the flooring and will complete upon their availability. Resident 60 was discharged to home on 9/29/22. The Warren wing spa room was cleaned. 2. All residents are at risk to have an environment which is not homelike. The facility will complete an audit of each room and common area of the facility to identify any additional repairs needed and cleanliness issues no later than October 24, 2022. 3. The Administrator will educate all staff on the Homelike Environment policy to ensure that the facility is kept clean and areas of disrepair are reported in the TELS system. The cited deficiency will be reviewed as well. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. Administrator or designee will complete walking rounds each day (Monday through Friday) in all common areas and five random resident rooms ensure cleanliness, equipment and furniture is clean and in good repair, walls and blinds are in good repair and resident rooms are decorated in a homelike environment. Audits will be weekly for four weeks and then monthly for three months.	

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F 584	Continued From page 6 *The mini-blind on the window had some of the slats broken and parts of them missing. *His wheelchair arm rests were cracked making them uncleanable. *The wheelchair leg rests and under carriage were caked with dust and other particles. *His bedside table was covered with dried substances and crumbs. The edges were peeling making it an uncleanable surface. 2. Observation and interview on 9/27/22 at 10:50 a.m. of resident 46's bedside table revealed: *It was covered in a white substance and had been like that for a few days. *He had not had anyone offer to clean it for him. *He was not aware the staff were responsible to ensure he lived in a clean environment. 3. Observation on 9/27/22 at 11:00 a.m. and at 2:07 p.m. of the east hallway shower room revealed: *A white coated wire shelf rack on the wall peeling and rusted. *The countertop was dusty, with fingernail trimmings, and an unidentified brush filled with white hairs. *Several bottles of soap, shampoo, conditioner, and lotion some with resident names and some with not scattered around the shower area and in the cupboard. *Paint coming off the ceiling above shower area. *A blue plastic basket in a cupboard with small manicure sticks, emery boards, 2 partially used rolls of paper tape, yellow highlighter, and several strands of gray hair. *The wooden cupboard on the wall had shelves with unfinished wood inside making it not a cleanable surface. -There had been multiple hairs stuck to the	F 584	Results of audits will be discussed by the Administrator at the monthly QAPI Meeting to identify trends or additional education needs and will include continuation or discontinuation of audits based on the findings.	

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F 584	Continued From page 7 surface of the shelves along with brown colored stains. *The fan on the wall was caked with gray and brown dust. *A scissors on the counter was covered in dust with a piece of white tape stuck to the blade and rust spots to top of blade near the black handle. *A set of 3 plastic drawers on the floor layered with dust particles and a used band aide stuck to the left side with what appeared to be blood on it. *The garbage can was full and had a soiled brief in it. *The window had a white spider web on it with small bugs and flies stuck in it. *A cloth covered chair in the corner with a Roho wheelchair cushion sitting in it. The cover of the cushion was soiled with a brown dried substance. 4. Observation on 9/27/22 at 12:12 p.m. of resident resident 14's wheelchair revealed: *The foot cushion was covered with dust particles. *The foot rests and under carriage was covered with dust and other particles. 5. Observation on 09/27/22 at 2:22 p.m. of the total lift in the east hallway outside of room 301 revealed: *The base of the lift was covered in dust particles. *The black plastic covering was missing on the left base leg, exposing the glue, and making it an uncleanable surface. 6. Observation on 9/27/22 at 4:02 p.m. of resident 20's doorway revealed the threshold was missing and there was about a one-fourth inch gap with brown colored build up. 7. Observation on 9/27/22 at 2:26 p.m. in resident	F 584		

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F 584	Continued From page 8 51's bathroom revealed: *Bathroom floor tiles were chipped and broken making the floor uncleanable. *Brown smears on the toilet lid. 8. Observation on 9/27/22 at 3:59 p.m. of a sit-to-stand lift in the east hallway revealed the foot rest and base legs were covered with brown and black dust particles. 9. Observation and interview on 9/27/22 at 4:53 p.m. with resident 45 revealed: *Pieces of paper and Kleenexes on the floor, and brownish dust balls under his roommate's bed. *An open tube of hemorrhoid cream, an open tube of Calmoseptine ointment, an open tube of silicone cream, an open bottle of powder on top of fridge next to a box of soda crackers, a box of Kleenex, and a bowl of what looked like apple crisp. *He was blind and not able to see whether his room was clean or not. *He was not aware the ointments, creams, and powder that were used on his body had been stored next to his food on top of his fridge. *He depended on staff to ensure his environment was kept tidy and clean. 10. Interview on 9/27/22 at 10:54 a.m. with certified nursing assistant (CNA) FF regarding resident 12's broken mini-blind revealed she had put in an electronic maintenance request form more than once, but it never was fixed. Interview on 9/27/22 at 2:22 p.m. with licensed practical nurse (LPN) BB regarding who was responsible to clean the East shower room revealed she: *Had thought the bath aide was to tidy it up and	F 584		

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F 584	Continued From page 9 then the housekeepers were to clean it. *Was not aware of how dirty it was. Interview on 10/04/22 at 12:48 p.m. with administrator A revealed: *There was no procedure for who was responsible to clean wheelchairs and mechanical lifts. *She was aware the wheelchairs and mechanical lifts were dirty and needed cleaned. *She had not implemented a process or procedure to ensure they were being cleaned. Interview on 10/04/22 01:08 p.m. and 1:39 p.m. with administrator A and regional nurse consultant X revealed: *There was not a policy for housekeeping procedures. *All bedside tables should be wiped down at least daily. *The provider did not have a procedure for who was responsible for what cleaning tasks. *The bath aide was responsible to clean the shower rooms. 11. Observation on 9/27/22 at 10:05 a.m. revealed a television monitor was on the bed side dresser next to resident 3's bed. The top of the monitor was leaned back against wall and was not secured to the wall. 12. Observation on 9/27/22 at 10:19 a.m. in resident 17's room revealed scrapes and black smudges on the wall beside his bed towards the head of the bed. 13. Observation on 9/27/22 at 10:21 a.m. revealed the material of the armrests on resident 5's wheelchair were torn exposing the stuffing	F 584		

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F 584	Continued From page 10 inside and making the armrests not cleanable. 14. Observation on 9/27/22 at 10:28 a.m. revealed gouges in the sheet rock on the wall beside resident 8's bed towards the head of the bed. 15. Observations on 9/27/22 at 10:29 a.m. revealed: *The shared bathroom between rooms 225 and 226 had a strong stale urine odor. *The wall on resident 43's side of the room was scraped and smudged with black marks. 16. Interview on 9/28/22 at 9:40 a.m. with housekeeper Q revealed she would report needed repairs on her daily cleaning sheet or a maintenance sheet that she would post weekly on the maintenance office door. 17. Observation on 9/28/22 at 4:15 p.m. revealed the window blinds in resident 49's room were crooked, and many were bent back out of shape. 18. Interview on 9/29/22 at 3:32 p.m. with maintenance personnel I revealed he was not aware of the concerns noted above but confirmed staff are supposed to report those in the electronic "TELS" system. 19. Observation on 10/3/22 at 3:09 p.m. in resident 24's room revealed: *The bed sheet had been loosened from the top left corner of the mattress and the pattern of the mattress was able to be seen through the cloth of the sheet. *The wall beside the bed had black smudges and scraped paint exposing the sheet rock.	F 584		

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F 584	Continued From page 11 20. Observation on 9/27/22 at 9:35 a.m. in resident 53's revealed: *There was a crack in the wall behind the resident's bed and nightstand. The drywall was exposed. *The rubber floorboard near the bathroom was peeling away from the wall. *There were spider webs in the corner of the resident's window. The spider webs were outside. 21. Observation on 9/27/22 at 9:45 a.m. in resident 278's room revealed: *There were five large gouges approximately six inches in length each behind the resident's bed. The drywall was exposed. *The rubber floorboard near the bathroom was peeling away from the wall. 22. Observation and interview on 9/27/22 at 11:18 a.m. with resident 277 in their room revealed: *There were scrapes and gouges in the wall behind the resident's bed and on the wall outside the bathroom door. The drywall was exposed. *Resident 277 said the gouges in the walls were there when he was admitted to the facility on 9/12/22. *He was not impressed with the condition of the room. 23. Observation on 9/28/22 at 8:44 a.m. revealed two large stains in the carpet outside of room 114. 24. Observation and interview on 9/28/22 at 9:10 a.m. with resident 60 in her room revealed: *She was admitted on 8/29/22. *There were scrapes in the wall behind and beside her bed. The drywall was exposed. *There were dents in the wall next to the bathroom.	F 584		

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	435039	A. BUILDING _____ B. WING _____	C 10/04/2022

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F 584	Continued From page 12	F 584		

*There were no decorations on her walls except for one calendar.
*Resident 60's birthday was 9/16/22 and she asked staff for a balloon. Staff told her they did not have any balloons.
*Resident 60 said she felt left out because her room was bare.
-She said one of her neighbors in the facility had a lot of birthday cards hung up in their room from when it was their birthday.

Interview on 9/29/22 at 4:04 p.m. with activities director E revealed she was not involved in helping residents decorate their rooms.

Interview on 9/29/22 at 4:05 p.m. with social services designee D revealed she:
*Recently started her position at the facility.
*Did not know who was responsible for assisting residents with making their rooms more homelike, but suspected that part of her duties would be to work with activities director E to help residents make their rooms more homelike.

25. Observation on 9/28/22 at 3:58 p.m. in the Warren wing spa room revealed:
*There were at least five dead bugs on the floor to the left of the whirlpool bathtub.

Interview on 9/29/22 at 3:34 p.m. with maintenance personnel I regarding the condition of the building revealed:
*He was not aware of the physical condition of the walls and floorboards on the Warren wing.
*He had started his position a couple of weeks ago and was trying to make note of everything he needed to address.
*Nursing staff had access to their electronic maintenance request forms, however neither

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F 584	Continued From page 13 housekeeping nor laundry had access. -Housekeeping and laundry had to verbally tell him maintenance requests or wrote their requests on paper to submit in his mailbox. 26. A policy on how staff put in a maintenance request for repairs had been requested on 9/29/22 at 5:30 p.m. Administrator A revealed the provider did not have a policy. A wheelchair and mechanical lift cleaning process and schedule had been requested on 10/3/22 at 5:30 p.m. Administrator A revealed the provider did not have a schedule or process to ensure they had been cleaned regularly. A housekeeping cleaning policy had been requested from the provider on 10/4/22 at 11:45 a.m. Administrator A revealed the provider did not have a policy.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600	1. Resident 71 was assessed for injuries on 9/27/22 and the event was reported to the SD DOH, Adult Protective Services and the local police department on 10/4/22. CNA W's employment was terminated. Resident 73 was assessed for injuries on 9/27/22 and the event was reported to the SD DOH, Adult Protective Services and the local police department on 10/12/22. The CNA W was terminated. 2. All residents are at risk for abuse and neglect occurring. 3. The Administrator has educated the HR director on ensuring past employees termination action is up to date and reviewed and approved by the Administrator prior to hiring any past employees.	11/2/22

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F 600	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to protect two of two residents (71 and 73) from mistreatment while receiving care from staff. Findings include: 1. Interview on 9/27/22 at 2:24 p.m. with resident 71 regarding her care revealed: *Resident 71 recalled on 9/25/22 after supper, but before bedtime, certified nursing assistant (CNA) W assisted her to go to the bathroom with the sit-to-stand aide. *CNA W did not put the sling on correctly and resident 71 slipped through the sling and landed hard onto the toilet. *Resident 71 said CNA W got upset with her and said, "I'm not going to take care of you again," and abandoned her in the bathroom. *She had to wait "a long time" for another aide to help her off the toilet. *Resident 71 said she felt mad at CNA W for leaving her, helpless because she could not stand up on her own, and sad as she cried after the incident. *She thought she had mentioned this incident at her care conference. Interview on 9/29/22 at 11:11 a.m. with director of nursing (DON) B and social services designee (SSD) D revealed: *Neither of them were aware of the incident mentioned above. *SSD D indicated they had resident 71's care conference earlier in the week and she mentioned having to wait a long time for staff to answer her call light, however resident 71 had not mentioned anything about the incident mentioned above.	F 600	4. The Administrator or designee will interview five random residents each week to ensure they have not experienced any abuse or neglect. Audits will be weekly for four weeks, and then monthly for three months. Additionally, as an ongoing measure, all applicants for rehire – their termination reason will be reviewed by the Administrator prior to hire. Results of audits will be discussed by the Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 600	Continued From page 15 Interview on 9/29/22 at 1:35 p.m. with SSD D revealed: *She talked with resident 71 to learn the full details of the incident. *Resident 71 told SSD D the same details of the incident mentioned above. *SSD D reviewed the working schedule from 9/25/22 and confirmed that CNA W had worked on that day and had been assigned to resident 71's hallway. *SSD D completed a grievance form, informed administrator A, and submitted reports to both adult protective services and the local police department. Interview on 9/29/22 at 2:22 p.m. with human resources director (HRD) H about CNA W's employee file revealed: *CNA W worked at the facility previously and was terminated from her position in January 2020 due to a substantiated allegation of abuse and neglect. *She was rehired in February 2021. *CNA W's employee file in the provider's electronic human resource software program indicated that she was terminated on 1/27/20 for the reason of "employee misconduct." *The provider had access to this information of "terminated for employee misconduct" upon the rehire process in February 2021. *HRD H admitted they should have investigated further on why CNA W was previously terminated before rehiring her. *HRD H said she should have uploaded the corrective action form from January 2020 to their electronic human resource software program so that the leadership team could all have access to the form.	F 600		

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F 600	Continued From page 16 -The corrective action form indicated CNA W had been terminated due to substantiated allegation of abuse/neglect. Interview on 9/29/22 at 2:47 p.m. with administrator A and regional nurse consultant (RNC) X revealed they: *Did not know that CNA W was previously terminated from the facility due to a substantiated allegation of abuse/neglect. *Would not have considered CNA W as a potential candidate for rehire if they knew about the previous termination. *Had not been aware of the incident between resident 71 and CNA W before 9/29/22. Interview on 10/3/22 at 3:36 p.m. with HRD H about her process for rehiring former employees revealed: *She reviewed the applicant's file in the provider's electronic human resource software program to learn why they previously left or why they were terminated from their position. *She confirmed again that she should have uploaded CNA W's termination papers from January 2020 into the program for easy access to review. *She was planning on conducting an audit of all employee files due to this incident. *She started to update the provider's "do not rehire" list. Interview on 10/4/22 at 11:17 a.m. with administrator A and RNC C regarding the incident revealed: *Administrator A interviewed the other staff members that worked on the evening of 9/25/22. -No other staff or residents voiced complaints about CNA W.	F 600		

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F 600	Continued From page 17 -The other staff members were not aware that CNA W abandoned resident 71 on the toilet. *They were finishing their investigation to submit to the South Dakota Department of Health (SDDOH). *Due to learning one of their employees had previously been terminated due to abuse and neglect, they committed to improve their hiring practices by thoroughly checking potential applicant's references, looking at their employee files, and keeping their "do not rehire" list updated. Review of resident 71's electronic medical record revealed: *She was admitted on 8/31/22. *She required extensive assistance with transfers. *Her brief interview for mental status score was 15, indicating she was cognitively intact. Review of CNA W's "Corrective Action Form" signed on 1/31/20 revealed: *The "Facts" section read, "Resident filed complaint. Investigation completed. [Allegation] of abuse/neglect substantiated. [SDDOH] report completed. Last day worked 1/26/20." Review of the provider's Abuse and Neglect policy revealed: *Page one, "Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment." *Page one, "Definitions of Abuse, Neglect, Exploitation, & Abuse Coordinator." -"Abuse: abuse is willful infliction of mistreatment,	F 600		

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F 600	Continued From page 18	F 600		

injury, unreasonable confinement, intimidation or punishment. Abuse assumes intent to harm, but inadvertence or careless behavior done it deliberately that results in harm may be considered abuse."
*Page one continued, "Types of abuse..."
-"2. Verbal."
-"3. Mental..."
-"5. Neglect..."
-"7. Involuntary Seclusion."
*Page two, "Verbal: verbal abuse includes but not limited to the use of oral, written or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing slash seeing distance."
-"Examples: name calling, swearing, yelling, threatening harm, trying to frighten the resident, racial slurs, etc."
*Page two continued, "Mental: mental abuse includes but is not limited to humiliation, harassment, threat of bodily harm, punishment, isolation (involuntary, imposed or seclusion) or deprivation to provoke fear of shame."
*Page two continued, "Involuntary Seclusion: Isolation of a resident against his/her will (involuntary, imposed seclusion)..."
-"Examples: statements to threaten or actually secluding, isolating or locking a resident in their room or a room or area by themselves; leaving a resident in their room all day who does not wish to be left alone in his/her room all day."
*Page three, "Neglect: Neglect is the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service

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F 600	Continued From page 19 the resident requires, but fails to provide that service." *Pages three and four indicated the screening process for potential applicants. There was no process mentioned for screening the facility's own personnel files for potential applicants who had worked at the facility previously. 2. Interview on 9/29/22 at 11:24 a.m. with resident 73 during the resident group meeting revealed: *He "sat on the toilet today for an hour before a medication aide arrived." He did not give a name. *She did not want to "take the time to get the lift equipment" and was going to physically help him stand up off the toilet. *He said no, but "she said, 'I'm the boss, we'll do it my way.'" *He refused again, and said he asked her what she was smoking, with some added offensive words. *The lift equipment was used to get him off the toilet. *Another staff person came and "told him to apologize to the medication aide" about his statement to her. Interview on 9/29/22 at 4:34 p.m. with licensed practical nurse (LPN) L revealed: *When asked if she was aware of an incident that morning involving resident 73, she reported he had made a statement to the medication aide about her being on drugs. *She said, "He exaggerates." Interview on 10/4/22 at 11:04 a.m. with DON B and RNC X revealed they agreed the incident should have been reported and investigated as an allegation of abuse and neglect.	F 600		

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F 600	Continued From page 20 Follow-up interview on 10/4/22 at 11:09 a.m. with LPN L revealed: *The medication aide reported resident 73's refusal to let her transfer him off the toilet. *She went with the medication aide to his room and said to both that she did not want to hear their arguments about how he should be transferred. *She then asked resident 73 "how he wanted it done," and he was transferred with the lift. *She did not report the incident for further investigation because "it was he said, she said situation." Interview on 10/4/22 at 11:10 a.m. with SSD D revealed she agreed the incident should have reported as an allegation of abuse so it could be investigated. Review of resident 73's electronic health record revealed: *On 8/29/21, a lift evaluation required a "sit to stand lift." *The care plan noted current interventions for assistance with activities of daily living (ADL) and risk for falls related to leg impairment due to post-polio plegia: -Revised on 2/18/22, "Using stand-aid for transfers. Can get on to toilet per self, needs stand-aid to get off of toilet." -Revised on 4/8/22, "Use of assistive device during transfers. Stand-aid." -Revised on 8/31/22 to "assist with ADL's/mobility as needed. Stand-aid and motorized w/c [wheelchair]." *On 9/3/22, the annual minimum data set (MDS) coded him as cognitively intact, without behavior symptoms, and needing weight bearing assistance of one person to transfer on and off	F 600		

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F 600	Continued From page 21 the toilet. *There was no progress note on 9/29/22 regarding the incident. *Transferring task documentation for 9/29/22 was not documented.	F 600		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656	1. The following corrections were made to resident care plans: Resident 15's has been educated and his care plan was updated to reflect that a recliner has been ordered and once received will replace his bed per his request. Resident 16 was interviewed at the time of survey for her fluid preferences and her plan of care updated. Resident 24's has been receiving his scheduled showers per his preference and his assistance needed has been added to his care plan. Resident 24 has a focus and interventions for constipation on his care plan. Resident 32 has been bathed per schedule and her plan of care has been updated to reflect her desired wake time of 0630 and assistance needed following any incontinent episodes. Resident 32 has been bathed per schedule and her plan of care has been updated for her desired wake time of 0630 and assistance needed following any incontinent episodes. Resident 24 had interventions added to her plan of care for constipation. Resident 36 transfer needs were added to her plan of care. Resident 277 discharged home on 10/13/2022. Resident 71's care plan will be udpated upon return to facility. Resident 20's bowel and bladder incontinence, toileting, and care for such were added to her plan of care. Resident 20's skin impairment/skin impairment risk and interventions put into place were added to her plan of care, as well as, other personal preferences important to her care. Resident 56's hot liquid interventions were added to her plan of care.	11/2/22

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F 656	Continued From page 22 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to develop and implement comprehensive person-centered plans of care for 9 of 9 residents (15, 16, 20, 24, 32, 36, 56, 71, and 277). Findings include: 1. Observation and interview on 9/27/22 at 11:27 a.m. with resident 15 revealed: *He was seated in his wheelchair in his room facing his bed with his back to the door of his room. *After knocking and receiving a response from him, the surveyor entered his room and noted that he appeared sleepy. *He commented he had to wait for staff to get into bed because it was "hard to get on it when doing it myself," and he had fallen before when he tried. *"Sleeping in the wheelchair is not good, it hurts my tailbone." *Sleeping on the bed was okay but he slept on it better during the day than at night. *He was "supposed to be getting a recliner" and the social service designee was working on it. Review of the 7/12/22 admission Minimum Data Set (MDS) assessment for resident 15 revealed: *The brief interview for mental status (BIMS)	F 656	2. All residents are at risk for having an incomplete plan of care. All resident's care plans have been reviewed and updated to ensure resident preferences and care needs are included on the plan of care. 3. The DON or Designee will educate all staff on the importance of the care plan to be accurate and include personal preferences, as well as, following the care plan interventions and reporting any resident changes or voiced preferences. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The DON or designee will review five random residents each month to ensure their care plans are up to date for resident care needs/preferences and interventions are being followed. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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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 656	Continued From page 23 coded him as having moderate cognitive impairment related to orientation to time and ability to recall. *His functional status for bed mobility and transfers required weight bearing assistance of one person. *The pain interview assessment coded him as having occasional pain at a rating of five that "limited his day-to-day activities." *He had shortness of breath when lying flat. Review of resident 15's care plan revealed: *No interventions to obtain a recliner in his room to address his preference and need for comfort. *Four focus areas addressed his need for comfort and assistance without noting use of a recliner: -"At risk for altered cardiovascular functioning" with an intervention initiated on 7/7/22 to "provide frequent rest periods." -An intervention revised on 7/14/22 to "encourage [resident name] to engage in healthy lifestyle including...healthy sleep habits" related to mood symptoms. -Assistance with activities of daily living (ADLs) with an intervention revised on 7/26/22 for one person assist with bed mobility and transfers. -At risk for falls with an intervention initiated on 9/13/22 to "add dycem [non-slip mat] under mattress to help prevent sliding." Review of progress notes between 7/19/22 and 10/3/22 revealed no notation regarding an effort to obtain a recliner for resident 15. Interview on 10/4/22 at 11:10 a.m. with social services designee (SSD) D revealed: *Resident had used a recliner at his previous long-term care (LTC) location. *He did not have a bed in his room at that	F 656		

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	435039	A. BUILDING _____ B. WING _____	C 10/04/2022

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F 656	Continued From page 24 location. *She knew he wanted a recliner and was working on it but confirmed she had not written a progress note for that. 2. Observations and interviews of resident 16 on 9/27/22 at 9:59 a.m., 9/28/22 at 4:26 p.m., and 9/30/22 at 10:10 a.m. revealed: *A water mug with a straw was on the overbed table on wheels positioned in front of her. *Her lips appeared dry, chapped, pale in color, and patches of flaky skin were present on the first observation. *Her teeth appeared dull with yellow build-up and dry. *She spoke with a muffled sound and moved her lips only slightly when she confirmed that she received enough to drink throughout each day. Comparative review of the 11/2/21 annual MDS assessment and the 7/8/22 quarterly MDS noted the following declines: -The BIMS scored her as cognitively intact then moderately impaired. -The mood interview coded her as reporting no symptoms but then "feeling tired or having little energy nearly every day." -Her upper extremity range of motion limitation was coded as just one side and then on both sides of her body. Review of resident 16's care plan revealed: *Two focus areas revised on 6/15/22 that did not include interventions for how staff would ensure adequate hydration related to: -Required assistance with activities of daily living (ADL) due to hemiparesis, including the ADL of eating. -Potential for altered nutritional status due to	F 656		

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F 656	Continued From page 25 multiple sclerosis. One intervention stated, "I like iced coffee with my meals with extra cream and sugar." Review of a physician order for resident 16 on 8/22/22 revealed: *A fluid goal of 1500 cc per day and to "write a schedule and make sure that this is getting done." *That was entered as an order to give 500 mL of fluids TID (three times a day). Interview on 9/30/22 at 9:30 a.m. with dietary manager (DM) F, while reviewing resident 16's 9/30/22 dietary meal tickets revealed she would be offered: *No fluids for breakfast. That meal was marked in large bold letters, "Do Not Serve" DM F stated it was her preference to sleep in during the morning and not be served breakfast. *One cup, 8 fluid ounces (Fl oz) or 237 mL of fluids at lunch *Two cups, 16 Fl oz or 474 mL of fluids at supper. Interview on 9/30/22 at 1:21 p.m. with administrator (ADM) A, director of nursing (DON) B, and regional nurse consultant (RNC) X revealed the immediate jeopardy removal plan (refer to F692, finding 1), "Ad Hoc QAPI [quality assurance performance improvement]," included: *"Resident #16 will be interviewed for preferences of beverages she prefer to consume." *"Resident #16 Care Plan will be updated to reflect the above." On 10/03/22 at 12:45 p.m., the survey team reviewed documentation provided by ADM A and RNC X to verify removal of the immediate jeopardy, including:	F 656		

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F 656	Continued From page 26 *An interview with resident 16 on 9/30/22 at 4:30 p.m. (the name of the interviewer was blank), which revealed: -She reported she felt she got enough fluid. -Her preferences included water and chocolate milk. *A one page large print plan for resident 16's "Fluid Expectations" including: -"AM Water Pass: 180mL per day -"Lunch: 420mL per day -"Afternoon Water pass: 360mL per day. -"Supper: 420mL per day. -"NOC shift: 360mL per day" *Resident 16's care plan had not been revised to reflect these fluid expectations. Interview on 10/3/22 at 1:40 p.m. with ADM A and RNC X when asked about who was responsible to ensure the care plan was updated, they indicated: *It was a team effort. *They thought DON B had updated the care plan to reflect the current changes for resident 16. *They were not aware it had not been updated. Interview and review of resident 16's revised care plan on 10/3/22 at 2:44 p.m. with ADM A and RNC C revealed: *It had not been revised to reflect her beverage preferences nor the one page plan noted above. *Instead, it stated, "Encourage and help the resident drink at least 1,500 cc's [sic] of fluid each day. 15cc's per pound of body weight is recommended (140 pound person should drink 2,100cc's [sic] per day)." 3. Observation and interview on 9/27/22 at 4:19 p.m. with resident 24 in his room revealed: *He gets a bath "when the girls have time," and	F 656		

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F 656	Continued From page 27 he had "only one since I have been here." *He "took medicine today" that helped him have a bowel movement, and he does not want to get constipated again. Review of resident 24's 7/25/22 admission MDS revealed: *His BIMS score noted he had moderately cognitive ability by answering correctly one of three time orientation questions and being able to recall two of three previously stated items. *He had no behavior symptoms prior to the admission MDS. *His preference for choosing between a tub bath, shower, bed bath, or sponge bath was coded as very important. *He required weight-bearing assistance of one person for most ADL tasks. *He was occasionally incontinent of bladder but always continent of bowel, and constipation was present. *The Care Area Assessments (CAAs) for: -ADL potential did not address further his preference for bathing. -Dehydration acknowledged a "newly present constipation" related to use of a diuretic [water pill]. Review of resident 24's care plan revealed: *No specific intervention related to bathing for the focus of assistance with ADLs revised on 7/29/22; the bathing intervention only said, "Assist resident with shower/bathing per schedule," initiated on 7/18/22. *No interventions for managing constipation related to two focus areas revised on 7/29/22: -Altered cardiovascular functioning with an intervention initiated on 7/18/22 to "administer medications as ordered."	F 656		

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F 656	Continued From page 28 -Dehydration and fluid volume loss risk related to diuretic use with an intervention initiated on 7/29/22 to "assess for signs and symptoms of dehydration." Review of the September 2022 bathing preference schedule noted resident 24's shower was scheduled on Wednesday each week. Review of resident 24's task documentation for August, September, and October 2022 revealed: *"ADL - Bathing prefers shower weekly" was noted as completed at least weekly in August, but he had not had a shower for 25 days between 9/2/22 and 9/28/22. It was noted "resident refused" on 9/5/22, but the only other date of 9/21/22 was noted as "not applicable." *Bowel documentation was noted as having occurred no more than 2 days apart in August, but there were greater than three days coded as "none" between the following dates: -Seven days between 8/25/22 and 9/2/22. -Five days between 9/2/22 and 9/8/22. -Four days between 9/11/22 and 9/16/22. -Four days between 9/16/22 and 9/21/22; except 9/19/22 was coded as "not applicable." -Eleven days between 9/21/22 and 10/3/22; except 9/23/22 and 10/2/22 were coded as "not applicable." Interview on 10/3/22 at 3:29 p.m. with licensed practical nurse (LPN) L revealed resident 24 "is the one that will say he is constipated all the time." Interview on 10/4/22 at 11:04 a.m. with DON B and RNC X revealed: *Resident 24 does say he is constipated frequently.	F 656		

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F 656	Continued From page 29 *They will review the bowel documentation and provide more information if his record shows that his bowel patterns indicate no irregularities. No further documentation was provided before the end of the survey. 4. Observation on 9/27/22 at 2:50 p.m. revealed resident 32 was visible through the bathroom door and the frame from the hallway. She was seated on the toilet and wiping herself. Her room door was open. Observation and interview on 9/27/22 at 4:52 p.m. with resident 32 revealed: *Staff do not come when her call light is on. *She likes to get up from bed at 6:30 a.m. and needs help getting out of bed but that is the worst time for getting help. *She said, "I wish they would answer the light" but sometimes they do not and then she "does the best" she can. *She reported she had not had a bath "for a long time," and "I suppose they don't have time." *There was an odor of stale urine in her room and on her person. *She reported she was "incontinent" but also used the bathroom and needed help "sometimes." *She also reported she "finally had a bowel movement." Interview with resident 32 on 9/28/22 at 4:25 p.m. revealed she had not yet had a bath. Observation on 10/3/22 at 3:08 p.m. revealed resident 32 was asleep on her bed. There was a strong urine odor in her room.	F 656		

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F 656	Continued From page 30 Interview on 10/3/22 at 3:23 p.m. with LPN L revealed: *The certified nursing assistants (CNAs) document bowel movements (BM) in the task documentation. *They are "supposed to let us know when a resident hasn't had a BM so we can listen to bowel sounds and give them medicine if needed." *Resident 32 "can toilet herself." The urine odor was because "she probably doesn't drink enough." Observation and interview with resident 32 on 10/4/22 at 10:54 a.m. revealed: *The odor in her room was not as strong. *She reported she would "get bath tomorrow," indicated she did not need a weekly bath and could give herself sink baths but they "don't give soap" for her to do that. Review of the September bathing preference schedule confirmed resident 32 was scheduled to receive a bath on Wednesdays. Comparative review of resident 32's 5/20/22 admission MDS and 8/3/22 quarterly MDS revealed: *Her BIMS was not completed at admission, but she scored as having moderately cognitive ability by answering correctly two of three time orientation questions and being able to recall two of three previously stated items. *Her preference for choosing between a tub bath, shower, bed bath, or sponge bath was coded as very important on the admission MDS. *On both MDS, she required weight-bearing assistance of one person for the ADL tasks of bed mobility, transfer, toilet use, and personal hygiene. The ADL of bathing was coded as	F 656		

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F 656	Continued From page 31	F 656		

"activity itself did not occur" on both MDS.
*She was occasionally incontinent of bladder on both MDS, but declined from always continent of bowel on the admission MDS to always incontinent of bowel on the quarterly MDS.
*Constipation was coded as not present on both MDS.
*The urinary incontinence CAAs completed with the admission MDS noted her as taking a diuretic, having urinary urgency, and needing assistance with toileting.

Review of resident 32's care plan revealed:
*"Psychosocial concerns" due to "emergency transfer" from another LTC location and "need to establish routines" without specific person-centered interventions initiated on 5/16/22 to "encourage her to be involved in the establishment of her daily routines..[that is] bath vs [versus] shower, time to wake and go to bed...honor resident's preferences."
*No specific intervention related to bathing for the focus of assistance with ADLs revised on 5/16/22; the bathing intervention only said, "Assist resident with shower/bathing per schedule," initiated on 5/15/22.
*The focus area of "alteration in bowel and bladder functioning," revised on 5/16/22, did not specifically address her urinary urgency related but included non-specific interventions to:
-"Apply moisture barrier to the peri-area after incontinent episode," initiated on 5/15/22.
-"Remind, offer and assist with toileting as needed," initiated on 5/15/22.

Review of resident 32's task documentation for August and September 2022 revealed:
*"ADL - Bathing prefers shower weekly" was noted as completed weekly in August, but:

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F 656	Continued From page 32 -She did not have a bath from 8/27/22 until 9/10/22, and not again before the last review of bathing documentation on 10/3/22. -8/31/22 was noted as "resident refused," and four dates (9/2/22, 9/9/22, 9/21/22, and 9/28/22) were noted a "not applicable." *Bowel documentation revealed frequent gaps of greater than 3 days coded a "none," as follows: -Nine days between 8/18/22 and 8/18/22. -Four days between 8/18/22 and 8/23/22. -Four days between 8/26/22 and 8/31/22. -Six days between 9/3/22 and 9/10/22. -Four days between 9/11/22 and 9/16/22. -Six days between 9/20/22 and 9/27/22. Interview on 10/4/22 at 11:04 a.m. with DON B and RNC X revealed they will review her bowel documentation and provide more information if her record shows that her bowel patterns indicate no irregularities. No further documentation was provided before the end of the survey. 5. Interview with resident 36 on 9/29/22 at 11:24 a.m. during the resident group meeting revealed: *She said the certified nursing assistants (CNAs) "have been too rough when lifting me and have hit my foot during transfers." *When asked if she had let anyone know about that, she replied, "They just disregard that and make into big deal." *One CNA was "talking on his phone while taking care of me." *Another time, "the sling was not fully attached, but her fall was reported as me having sat down instead." Review of the admission lift evaluation on 3/22/22	F 656		

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F 656	Continued From page 33	F 656		

for resident 36 revealed:
*She was unable to "stand, pivot, & [and] walk with no assistance or with limited assistance" and "bear at least 50% [percent] on at least 1 leg."
*The type of lift required was a sit to stand.

Review of resident 36's electronic health record revealed a general progress note dated 3/26/22 that noted:
LPN L was "called to resident's room by [CNA M]."
*"Resident [was] sitting on the floor with her back against the bed."
*CNA M and "resident state that there was no fall."
*CNA M lowered the resident "to the floor to prevent her from sliding out of the sling on the stand assist."
*The progress note included checkmarks so that it would "show on the Shift Report" and "Show on the 24 Hour Report."

Review of resident 36's care plan revealed:
*The focus for "assistance with ADL's" revised on 4/24/22 included interventions:
-Initiated on 3/22/22 to "Provide DME [durable medical equipment] if needed (wheelchair, cane, walker, etc.)," but there was no intervention to use a sit-to-stand lift for transfers, except:
-Initiated on 7/1/22 for a "restorative nursing programs" for "transfers-sit to stand 10 reps, safety training."
6. Observation on 9/28/22 at 5:40 p.m. during supper service in the Warren dining room revealed CNA R served coffee to resident 277.

Interview at that same date and time with resident 277's wife revealed she:
*Wondered why CNA R served coffee to resident

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F 656	Continued From page 34 277 because both she and her husband were active Seventh-Day Adventists. *Explained that Seventh-Day Adventists practiced certain dietary restrictions, such as refraining from drinking caffeinated beverages and eating pork. Interview on 9/29/22 at 10:44 a.m. with CNA/CMA EE regarding resident's food preferences revealed: *Food preferences were usually printed on resident's meal tickets and were in the resident's "quick view" in their electronic medical record. *CNA/CMA EE confirmed there was no information in resident 277's electronic medical record regarding his food preferences. Interview on 9/29/22 at 10:58 a.m. with DM F regarding his role in the care planning process revealed: *He had not been interviewing residents for their food preferences due to being short-staffed in the dietary department. *He thought the social worker was adding dietary preferences to the care plan. *He was aware that resident 277 refrained from eating pork, however he was not aware that resident 277 also did not drink caffeinated beverages. -He assumed resident 277 was a Muslim because he did not eat pork. -He was not aware that resident 277 was a Seventh-Day Adventist. *He confirmed that resident 277's meal tickets included "NO PORK" in the "notes" section of the meal tickets. Interview on 9/29/22 at 1:47 p.m. with SSD D regarding her role in the care planning process	F 656		

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F 656	Continued From page 35 revealed she: *Did not add dietary preferences to resident's care plans. *Assumed the dietary manager completed the nutrition and dietary preferences portion of the care plan. *Was aware that resident 277 did not eat pork. *Was unaware that resident 277 was a Seventh-Day Adventist and did not drink caffeinated beverages. *Did not know who was responsible for finding out dietary preferences/allergies/intolerances. Review of resident 277's electronic medical record revealed: *His diet order read "Consistent Carbohydrate (CCHO) diet. Regular texture, Nectar thick liquids consistency, Mildly Thick Liquids for Diabetic diet" which was ordered on 9/12/22. *His care plan included an intervention of "Prescribed diet is heart healthy," which was initiated on 10/3/19. -The "Prescribed diet is heart healthy" intervention was from a previous stay at the facility. *Resident 277's care plan did not indicate religious dietary preferences of no pork or no caffeinated beverages. 7. Interview on 9/27/22 at 3:07 p.m. with resident 71 regarding her overall health condition revealed: *She was feeling weaker than when she was admitted on 8/31/22. *She needed more assistance from staff and a sit-to-stand aide to get up from her chair because she felt her knees would buckle under her. Interview on 9/29/22 at 4:30 p.m. with registered	F 656		

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F 656	Continued From page 36 nurse (RN) Z regarding resident's mode of transferring revealed: *Staff found out how to transfer a resident in the electronic medical record. *She expected a resident's mode of transferring would be on the care plan. *She could not find how staff were supposed to transfer resident 71 in her electronic medical record or care plan. Interview on 9/29/22 at 4:44 p.m. with director of nursing (DON) B regarding resident's mode of transferring revealed she expected a resident's mode of transferring would be on the care plan. Review of resident 71's care plan revealed: *She required extensive assistance with transfers. *Her care plan did not mention how staff were supposed to transfer resident 71. 8. Interview on 09/27/22 at 4:02 p.m. with resident 20 revealed she: *Thought she had a sore on her bottom. *Liked to sleep in until about 10:00 a.m. and then go to bed early in the evening. *Was dependent on staff assistance with a mechanical lift to get in and out of the bed and wheelchair. *Most days she would be in the wheelchair until they put her to bed for the night. *Was incontinent of both bowel and bladder and did not always know when she was soiled. *Usually did not get changed from the time the staff assisted her into the wheelchair in the morning until they assisted her back into bed in the evening. *She was currently taking an antibiotic for an	F 656		

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F 656	Continued From page 37 urinary tract infection (UTI). Observation on 9/28/22 at 10:51 a.m. of resident 20 while receiving personal cares from CNAs AA and FF and LPN BB revealed: *She had been incontinent of bowel and bladder and was dependent on the staff to clean and change her. *She had small pinpoint open areas to her coccyx area. *LPN BB applied medicated cream to the area and applied skin fold dry sheets into her abdominal folds. Review of resident 20's electronic medical record revealed she had: *A stage I facility acquired pressure ulcer to her low back that was healed on 9/19/22. -No other documentation was present to show that the area had opened again. *Started an antibiotic on 9/23/22 and was to be on the medication for five days related to an UTI. Review of resident 20's revised 7/21/22 care plan revealed: *She was dependent on two staff for bed mobility, dressing, and personal hygiene. *She required a ceiling lift for all transfers. *She had actual skin impairment related to chronic kidney disease. -Had not indicated what the impairment was or where it was located. *It had not addressed the fact that she had a pressure ulcer or that she was at risk for developing a pressure ulcer. *She did have an air mattress and wheelchair cushion. *She was to be turned and repositioned as needed.	F 656		

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F 656	Continued From page 38 *She was to be kept clean and dry. *It had not indicated that she was incontinent of bowel and bladder. *It had not indicated how she was toileted or how often she should have been assisted with incontinence care. *It had not indicated she currently had an UTI or was at risk for an UTI. *It had not indicated her personal preferences for when she liked to get in and out of bed. Interview on 10/03/22 at 4:00 p.m. DON B regarding resident 20's care plan revealed: *The air mattress and wheelchair cushion were put into place on 2/25/22. *No new interventions had been added since the development of the pressure ulcer. *She thought resident 20 should be turned and repositioned at least every two hours. *The pressure ulcer and the resident 20's risk of developing a pressure ulcer should have been addressed in the care plan. *Her skin impairment was not related to her chronic kidney disease. *The care plan should have indicated she currently had an UTI and was at risk for developing an UTI. *Resident preferences should be included in the care plan. 9. Review of resident 56's electronic medical record revealed: *She had been hospitalized from 8/23/22 through 8/30/22. *Discharge orders from the hospital revealed she had two large serum filled blisters to her abdomen from a coffee burn that occurred during her hospital stay. *On 8/30/22 upon her return to the facility a hot	F 656		

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F 656	Continued From page 39	F 656		

liquid safety evaluation was completed and indicated she was at risk for hot liquid safety.
-The evaluation had a text box at the bottom with instructions to add the interventions in the box.

Review of resident 56's revised 6/15/22 care plan had not addressed:
*Her risk for hot liquid safety.
*Interventions put into place to prevent further hot liquid injuries.

Interview on 10/03/22 at 4:13 p.m. with DON B regarding resident 56's care plan revealed:
*The resident's risk for hot liquid injury should be care planned and interventions put into place to ensure it would not happen again.
*The charge nurse does the assessments when residents are admitted or return from a hospitalization.
*The interdisciplinary team is responsible to update care plans.

10. Review of the provider's September 2019 Care Planning policy revealed:
*"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made:
1. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations.
2. Each resident has the right to be happy, continue their life-patterns as able, and feel comfortable in their surroundings.
3. Care planning is constantly in process; it

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F 656	Continued From page 40 begins the moment the resident is admitted to the facility and doesn't end until discharge or death. 4. Each resident is included in the care planning process and encouraged to achieve or maintain their highest practicable physical and mental abilities through the nursing home stay. 5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total 'plan of care.' Physician's orders are referenced in the resident's care plan, but not rewritten into that care plan. 6. The DON will be responsible for holding the team accountable to initiating and completing the Admission care plan within 48 hours and the long-term care plan by day 21 and updated as necessary thereafter." *"5. Interventions act as the means to meet the individual's needs (not to continue outmoded institutional practices). The "recipe" for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met. Assessment tools are used to help formulate the interventions (they are not THE intervention)." *"9. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. When changes are made in the EHR [electronic health record] Care plan dates, time and name/initials are automatically entered."	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658	1. Resident 56 is being weighed and primary care provider is notified of any weight changes per order. No immediate correction could be made for resident 20 receiving medication from an unsigned order. The facility has obtained the provider's signature for that order.	11/2/22

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F 658	Continued From page 41 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review the provider failed to: *Follow a physician's order for one of one resident (56) who was to have daily weights and have the physician updated with changes. *Ensure a physician's order was signed for one of one resident (20) who received an antibiotic. Findings include: 1. Review of resident 56's electronic medical record revealed an order with a start date of 8/31/21: "Daily Weight, If weight increases by 2-3 lbs [pounds] in a day or 5 lbs in a week, notify PCP [primary care provider]/Attending MD [medical doctor]." Review of resident 56's electronic medical record revealed: *She had weights entered on these dates: -8/31/2022 at 7:00 a.m. her weight was 312.6 pounds (Lbs). -9/6/2022 at 5:48 p.m. her weight was 312.8 Lbs. -9/7/2022 at 5:38 p.m. her weight was 305.6 Lbs. -9/8/2022 1:28 p.m. her weight was 305.7 Lbs. -9/9/2022 at 5:20 p.m. her weight was 317.4 Lbs. -9/13/2022 at 7:00 a.m. her weight was 317.5 Lbs. -9/23/2022 at 7:00 a.m. her weight was 320.0 Lbs. -9/23/2022 at 9:35 a.m. her weight was 318.6 Lbs. -9/26/2022 at 9:45 a.m. her weight was 320.0 Lbs. -9/26/2022 at 4:19 a.m. her weight was 314.2 Lbs.	F 658	2. All residents are at risk for physician orders not being followed. All residents with daily weights have been reviewed to ensure notification parameters are in place and residents are being weighed per order. 3. The DON or Designee will educate all nurses on following physician orders and notification when outside of ordered parameters. The nurses will also be educated on ensuring all medical orders are signed by the provider prior to noting and carrying out the order. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The DON or designee will review five random residents each month to ensure physician orders are followed, including outside parameter notifications, and that all orders must be signed by the ordering provider prior to the nurse noting and carrying out the order. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 658	Continued From page 42 -9/29/2022 at 10:46 a.m. her weight was 314.0 Lbs. *There was no documentation: -A weight had been obtained on 22 days in September 2022. -A doctor had been notified of her weight changes. -Why the weights had not been obtained daily. Review of resident 56's revised 6/10/22 care plan revealed to "obtain weight as ordered." Interview on 10/3/22 at 4:17 p.m. with director of nursing (DON) B regarding resident 56 revealed: *Her daily weight had been missed on several days. *The charge nurse was responsible to ensure it was obtained daily. *She was not aware the daily weights were not being obtained. *The doctor should have been notified with weight changes. *The doctor should have been notified the order was not being followed daily. *Agreed there was no documentation of physician notification. 2. Review of resident 20's medical record revealed a lab result with an order hand written on it for Cefuroxime 250 mg by mouth twice a day for five days. *The order was not signed. *It did not indicate who had written the order. *It was noted on 9/23/22 by an unidentified person. Interview on 10/3/22 at 3:55 p.m. with DON B regarding resident 20's order for Cefuroxime revealed she had agreed the physician had not	F 658		

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F 658	Continued From page 43 signed the order. 3. Review of the provider's May 2021 Following Physician Orders policy revealed: It had not addressed what to do if the physician's order was not followed or signed.	F 658		
F 677 SS=F	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure 11 of 11 sampled residents (12, 13, 14, 20, 23, 24, 25, 32, 45, 56, and 71) received baths timely per their preference, or at least weekly. Findings include: 1. Interview on 9/27/22 at 2:24 p.m. with resident 71 regarding her care revealed: *She had not been feeling well on 9/25/22 when it was her scheduled bath day, and she declined having a bath. *Staff reapproached her later in the day on 9/25/22, however resident 71 was still not feeling well and she declined the bath again. *Staff did not reschedule her bath for any other day that week, telling her she would have to wait until the following week for a bath. Review of resident 71's electronic medical record revealed: *She was admitted on 8/31/22. *She did not receive a bath until 9/13/22.	F 677	1. Residents 71, 23, 12, 13, 14, 20, 25, 45, 56, 24, 32 have received a bath and are being bathed per preference/schedule. All resident's care plans have been updated to include resident preferences and type of assistance needed. An electric razor was obtained for Resident 14 and Resident 32 was provided with soap. 2. All residents are at risk for not having their bathing hygiene needs met. All resident preferences have been obtained and their plan of care updated for these preferences. 3. The DON or Designee will educate all nursing staff on the importance of ensuring the bathing activity occurs, men are shaved and if they do not have a razor to let administration know. Staff will be educated on reapproaching/ and offering rescheduling of a bath when a resident refuses. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The DON or designee will review the bathing schedule each day Monday through Friday and on Monday for the weekend to ensure bathing is being performed as scheduled. Additionally, the DON will observe five random residents each week to ensure residents appear clean and well groomed. Audits will be weekly for four weeks, and then monthly for three months.	11/2/22

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F 677	Continued From page 44 *She required extensive assistance with transfers, and limited assistance with personal hygiene. *Her brief interview for mental status (BIMS) score was 15, indicating she was cognitively intact. *Her care plan did not indicate bathing preferences, such as how many times per week, or if she preferred a whirlpool bath over a shower or bed bath. *Resident 71 was supposed to have baths on Sundays per the provider's September 2022 bathing schedule. 2. Observation and interview on 9/27/22 at 4:33 p.m. with resident 23 revealed: *Her hair was wet and combed. *She had just washed her hair in the sink because she had not had a shower in days. *She was "fed up" with going for so long without showering and was annoyed that no one helped her shower before her doctor's appointment that was scheduled the next day. Review of resident 23's electronic medical record revealed: *She was admitted on 12/21/18. *She had a BIMS score of 13, indicating she was cognitively intact. *Her care plan had an intervention of "Assist of one staff with shower/bathing. Prefers showers 2x/week. I usually like my shower before my doctor appointments, otherwise if no appointment, I like my shower in the morning. Provide assistance with washing hair. Sometimes, I wash my hair in the sink in my room." *Bathing record report generated from 8/1/22-9/29/22 revealed she:	F 677	Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 677	Continued From page 45 -Only received one shower in August, on 8/23/22. -Received only two showers so far in September, on 9/4/22, and 9/23/22. Review of the provider's August 2022 and September 2022 bathing schedule revealed: *In August, resident 23 was supposed to have a shower on Fridays at 8:00 a.m. *In September, resident 23 was supposed to have a shower on Fridays. 3. Interview on 9/27/22 at 10:30 a.m. with resident 12 revealed he did not get a bath regularly. Review of resident 12's bathing documentation from 8/1/22 through 9/29/22 revealed he had received a bath on 8/30/22, 9/13/22, 9/20/22, and 9/27/22. Review of resident 12's 7/1/22 Quarterly Minimum Data Set (MDS) revealed: *His BIMS was 13, indicating his cognition was intact. *He was dependent on one staff for bathing. Review of the provider's bath schedule for resident 12 revealed in: *August 2022, he was scheduled for baths on Tuesdays and Fridays. *September 2022, he was scheduled for a shower on Tuesdays. Review of resident 12's revised 10/19/21 care plan revealed to "assist resident with shower/bathing per schedule." 4. Review of resident 13's bathing documentation between 8/1/22 through 9/29/22 revealed he had:	F 677		

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F 677	Continued From page 46 *Refused a bath on 8/31/22. *Had received a bath on 9/4/22 and 9/22/22. *On 9/23/22 the bathing documentation is documented as not applicable. Review of resident 13's 7/1/22 quarterly MDS revealed: *His BIMS was 5, indicating his cognition was moderately impaired. *He required extensive assistance with bathing. Review of the provider's bath schedule for resident 13 revealed in: *August 2022, he was not on the schedule. *September 2022, he was scheduled for a shower on Thursdays with hospice and a whirlpool on Fridays. Review of resident 13's revised 1/31/22 care plan indicated resident was to get a bath or shower twice a week. 5. Observation on 9/27/22 at 12:12 p.m. of resident 14 revealed his: *Hair was not combed and was matted in the back. *Facial hair was about one-forth inch long. Interview on 9/28/22 at 3:54 p.m. with certified nursing assistant (CNA) AA regarding resident 14 revealed he did not have a razor and only got shaved on his bath days. Observation on 10/3/22 at 4:30 p.m. and on 10/4/22 at 9:22 a.m. of resident 14 revealed his: *Hair was not combed and was matted in the back. *Facial hair was about one-half inch long.	F 677		

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F 677	Continued From page 47 Review of resident 14's bathing documentation between 8/1/22 through 10/3/22 revealed he had a bath on 9/17/22, 9/24/22, and 10/1/22. Review of resident 14's 7/1/22 quarterly MDS revealed: *His BIMS was 3, indicating severely impaired cognition. *He required extensive assist with toilet use and personal hygiene. *He had not received a bath in the last 7 days. Review of resident 14's revised 4/21/21 care plan revealed: "Assist [resident's name] with shower/bathing per schedule. [Resident name] prefers1-2 showers per week. If he refuses, try again later. [Resident's name] can become very verbally and physically aggressive. Approach slowly and speak slowly and softly to him." Review of the provider's bath schedule for resident 14 revealed in: *August 2022, he was scheduled for Wednesdays. *September 2022, he was scheduled for a shower on Saturdays. 6. Interview on 9/27/22 with resident 20 revealed she had gone several weeks without a bath due to having to wear leg braces. Review of resident 20's bathing documentation between 8/1/22 through 9/28/22 revealed she had: *Received a bath on 9/1/22 and 9/5/22. *Refused a bath on 9/22/22. -There had been no documentation of why or if another time had been set up to make up the missed bath.	F 677		

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F 677	Continued From page 48 Review of resident 20's 7/16/22 significant change MDS revealed: *Her BIMS was 13, indicating her cognition was intact. *She was dependent on two staff for bathing. Review of resident 20's revised 7/21/22 care plan revealed: *"Assist [resident's name] with shower/bathing per schedule." *She was dependent on one staff for bathing. Review of the provider's bath schedule for resident 20 revealed in: *August 2022, she was scheduled on Wednesdays. *September 2022, she was scheduled on Thursdays. 7. Review of resident 25's bathing documentation between 8/1/22 through 9/28/22 revealed she had received a bath in: *August on 8/8/22, 8/11/22, 8/12/22, 8/15/22, and 8/23/22. *September on 9/20/22 and 9/23/22. -She had refused her bath on 9/27/22. Review of resident 25's 7/19/22 quarterly MDS revealed: *Her BIMS was not assessed. *She had not received a bath in the last 7 days. *She required extensive assist with personal hygiene and toilet use. Review of resident 25's 4/18/22 admission MDS revealed: *Her BIMS was 14, indicating her cognition was intact.	F 677		

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F 677	Continued From page 49 *She had not received a bath in the last 7 days. *She required extensive assist with personal hygiene and toilet use. Review of resident 25's 4/17/22 care plan revealed: "Assist resident with shower/bathing per schedule." Review of the provider's bath schedule for resident 25 revealed in: *August 2022, she was not on the bath schedule. *September 2022, she was scheduled for a bed bath on Tuesdays and Fridays. 8. Interview on 9/27/22 at 4:53 p.m. with resident 45 revealed he had to go without a shower at times because there was not enough staff. Review of resident 45's bathing documentation from 8/1/22 through 9/28/22 revealed he had: *A bath on 8/29/22, 9/1/22, 9/8/22, and 9/15/22. *Refused a bath on 9/22/22. Review of resident 45's 8/18/22 quarterly MDS revealed: *His BIMS was 15, indicating his cognition was intact. *He needed substantial/maximal assistance with bathing. Review of resident 45's care plan revealed: *"He requires assistance of 1 staff for showers. *He showers weekly." Review of the provider's bath schedule for resident 45 revealed in: *August 2022, he was scheduled on Mondays and Thursdays. *September 2022, he was scheduled on	F 677		

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F 677	Continued From page 50 Thursdays. 9. Review of resident 56's bathing documentation from 8/1/22 through 9/28/22 revealed: *She had a bath on 8/9/22, 9/5/22, and 9/8/22. *Documentation on 9/22/22 for whether she had a bath or not stated "Not Applicable." Review of resident 56's 9/6/22 significant change MDS revealed: *Her BIMS was 13, indicating her cognition was intact. *She had not received a bath in the last 7 days. *She required extensive assist with personal hygiene and dressing. Review of resident 56's 1/24/22 care plan revealed: "Assist resident with shower/bathing per schedule" Review of the provider's bath schedule for resident 56 revealed in: *August 2022, she was scheduled for Mondays and Thursdays. *September 2022, she was scheduled for shower on Thursdays. 10. Interview on 9/28/22 at 3:54 p.m. with CNA AA regarding resident bathing revealed: *Residents were supposed to get a bath twice a week, but usually only got one a week. *There was a bathing schedule posted in the central shower room. Interview on 9/28/22 at 4:09 p.m. with licensed practical nurse BB regarding resident bathing revealed: *All residents get one bath a week. *If a resident wanted more than one bath a week	F 677		

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F 677	Continued From page 51 they could request one. *The bath aide would often get pulled to the floor if they were short staffed and then the baths did not get done for that day. Interview on 10/03/22 at 3:48 p.m. with director of nursing B regarding resident bathing revealed: *Baths were not done when the bath aide was pulled to work the floor. *All residents should get a bath at least once a week and preferably twice a week. Interview on 10/4/22 at 1:25 p.m. with administrator A and regional nurse consultant X regarding resident bathing revealed: *They had known residents were not getting their baths as scheduled. *The bath aide was getting pulled to work the floor and then baths were not getting done. *They were making some staffing changes in the facility to ensure the bath aide would not get pulled to the floor. 11. Review of the provider's September 2019 Bathing policy revealed: *"The resident has the right to choose timing and frequency of bathing activity. *Bathing preferences are asked upon admission and during quarterly care conference." 12. Observation and interview on 9/27/22 at 4:19 p.m. with resident 24 revealed: *He gets a bath "when the girls have time," and he had "only one since I have been here." Review of resident 24's 7/25/22 admission MDS and care plan revealed: *His preference for choosing between a tub bath,	F 677		

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F 677	Continued From page 52 shower, bed bath, or sponge bath was coded as very important. *There was no specific intervention related to bathing for the focus of assistance with ADLs revised on 7/29/22; the bathing intervention only said, "Assist resident with shower/bathing per schedule," initiated on 7/18/22. Review of the September 2022 bathing preference schedule noted his shower was scheduled on Wednesday each week. Review of task documentation for August, September, and October 2022 revealed: *The "ADL - Bathing prefers shower weekly" was noted as completed at least weekly in August, but he had not had a shower for 25 days between 9/2/22 and 9/28/22. *It was noted "resident refused" on 9/5/22 and 9/21/22 was noted as "not applicable," which was his scheduled bath day. 13. Observation and interview on 9/27/22 at 4:52 p.m. with resident 32 revealed: *She had not had a bath "for a long time," and "I suppose they don't have time." *There was an odor of stale urine in her room and on her person. Interview with resident 32 on 9/28/22 at 4:25 p.m. revealed she had not yet had a bath. Observation on 10/3/22 at 3:08 p.m. revealed she was asleep on her bed. There was a strong urine odor in her room. Observation and interview with resident 32 on 10/4/22 at 10:54 a.m. revealed: *The odor in her room was not as strong.	F 677		

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F 677	Continued From page 53 *She reported she would "get bath tomorrow," indicated she did not need a weekly bath, and could give herself sink baths but they "don't give soap" for her to do that. Review of the September 2022 bathing preference schedule confirmed she was scheduled to receive a bath on Wednesdays. Comparative review of resident 32's 5/20/22 admission MDS and 8/3/22 quarterly MDS and her care plan revealed: *Her preference for choosing between a tub bath, shower, bed bath, or sponge bath was coded as very important on the admission MDS. *"Psychosocial concerns" due to "emergency transfer" from another LTC location and the "need to establish routines," initiated on 5/16/22, did not have specific person-centered interventions to "encourage her to be involved in the establishment of her daily routines, i.e., [that is] bath vs [versus] shower, time to wake and go to bed...honor resident's preferences." *No specific intervention related to bathing for the focus of assistance with ADLs revised on 5/16/22; the bathing intervention only said, "Assist resident with shower/bathing per schedule," initiated on 5/15/22. Review of resident 32's task documentation for August and September 2022 revealed the task of "ADL - Bathing prefers shower weekly" was noted as completed weekly in August, but: *She did not have a bath for 13 days, from 8/27/22 until 9/10/22. *On 8/31/22, it was noted as "resident refused," and two dates (9/2/22 and 9/9/22) were noted as "not applicable." *She had not had a bath since 9/10/22 through	F 677		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	Continued From page 54 last review of bathing documentation on 10/3/22 during the survey, 23 days. *"Not applicable" was coded on 9/21/22 and 9/28/22, which were her scheduled bath days.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and procedure review, the provider failed to: *Follow up and monitor for signs and symptoms for a urinary tract infection (UTI) resulting in hospitalization for one of one sampled resident (12). *Provide sufficient incontinence and peri care to avoid development of a UTI for one of one sampled resident (55). *Provide ongoing educational opportunities for one of one sampled resident (40) who self-cares for his ostomy. *Provide fluids that were thickened to the correct consistency based on physician's orders for one of one sampled resident (277). *Address all aspects of a resident's pain and implement interventions for one of one sampled resident (15). Findings include:	F 684	1. No immediate correction could be made for Resident 12's catheter bag being set on his lap. CNA M was educated on this at the time of survey. No immediate correction could be made for the missed catheter change documentation on 5/26/22 or the failure to notify Resident 12's provider of this abdominal pain on 6/1/22. Resident is without complaints and his catheter is being changed per schedule/order. No immediate correction could be made for resident 55's past hospitalization and UTI. Resident is without complaints and peri care/catheter care is being performed per standards. Resident 40 received education on ostomy cares and catheter tubing and bag placement while he is in his room. Staff will attempt to clean his room daily as he allows and observe catheter and tubing to ensure it is not on the floor. Resident 277 was provided the proper fluid consistency until he was discharged to home on 10/13. A recliner has been obtained for Resident 15 to assist with his comfort. 2. All residents with catheters are at risk for not receiving appropriate care of catheter to prevent UTIs. CNA staff have received pericare and catheter care competencies and education. All residents with pain are at risk for not having non-pharmacological interventions included in their pain regime. All residents with pain have been reviewed and interviewed for non-pharmacological interventions and those have been added to the resident's plan of care.	11/2/22

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F 684	Continued From page 55 1. Observation and interview on 9/27/22 at 10:54 a.m. of resident 12 in his room while certified nursing assistants (CNA) M and FF assist him to get ready for a shower. *CNAs M and FF used the mechanical total body lift to move him from his wheelchair and into bed. *They undressed him in the bed, emptied his catheter bag, set the catheter bag on his lap, and with the mechanical lift assisted him into the shower chair. *CNA M pushed him to the east shower room in the shower chair with the catheter bag on his lap. *When she got him in the shower, she then moved the catheter bag below the bladder and attached it to the side of the shower chair. Interview on 9/27/22 at 11:32 a.m. with CNA M regarding the above observation revealed: *She had been educated to empty the catheter bag prior to transferring a resident so then the bag could be placed in their lap so it would not get pulled out. *She had agreed there could still be urine in the tubing of the bag that could go back into the bladder. *Resident 12 had a history of UTIs. Interview on 9/27/22 at 11:52 a.m. with licensed practical nurse BB regarding resident 12's catheter revealed: *She had changed the resident's catheter recently with no issues. *He was not currently on antibiotics for UTI. *Did have a history of UTIs. *Had not had an infection or hospitalization recently. *The CNAs put the catheter bag in his lap because resident 12 is nervous it will get pulled on.	F 684	3. The DON or Designee will educate on the following: all nursing staff on catheter and pericare for UTI prevention, including ensuring the catheter is below the level of the bladder and the bag and tubing is not on the ground. Nurses will be educated to ensure residents who wish to perform self-care should have on-going education on the procedure. Nursing staff will be educated on ensuring non-pharmacological pain interventions are part of the resident's pain regime. All staff will be educated on where to find the resident's diet and fluid consistency, as well as any dietary or religious restrictions. The Social Services Director will be educated to obtain any religious dietary restrictions upon admit and provide that information to the dietary department and include it on the plan of care. The education will occur no later than November 2, 2022, and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The DON or designee will audit the following: Observe five random catheter cares each week to ensure pericare and catheter care is performed correctly; Observe five random meals to ensure residents are receiving the correct diet/consistency and are not served anything that is a dietary/religious restriction. The DON will interview five random residents to ensure pain regime is adequate and includes any non-pharmacological interventions. The DON will observe any self-cares performed by the resident each week to ensure procedure is performed correctly and provide any education to the resident if needed. Audits will be weekly for four weeks, and then monthly for three months.	

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F 684	Continued From page 56 Review of resident 12's medical record revealed: *4/26/22 he had seen a urologist and a foley catheter was inserted. He was to have the catheter changed every 30 days. *There was an order on his treatment administration record (TAR) to change his catheter on 5/26/22. This had not been signed as completed. *A nurses note from 6/1/22 at 5:58 p.m.: "Resident c/o [complaints of] Right side abdominal pain that started this morning et [and] gradually got worse thru out the day pain 6/10 per resident; writer emptied 300cc [cubic centimeter] of dark light brown urine per cath [catheter]bag. PRN [as needed] Tramadol given as ordered for pain PRN. VS [vital signs] 98.9-98-20-158/82. Will continue to monitor. *No other documentation regarding residents' abdominal pain until 6/3/22 at 5:10 p.m. and a nurses note indicated resident was sent to the emergency department for persistent abdominal pain that was not relieved with pain medications. *6/3/22 he was seen by Avel eCare via a two-way audiovisual telehealth system for evaluation of his abdominal pain. -Review of the note from this visit had indicated: --The pain had started the night before. --No mention of the symptoms he was having on 6/1/22. --His abdomen was distended and tender. --Plan was to transfer him to the emergency department to rule out appendicitis. Review of resident 12's 4/29/22 care plan revealed: *"[Resident name] will show no signs and symptoms of urinary infection." *"Change foley catheter per facility protocol or MD	F 684	Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 684	Continued From page 57 [medical doctor] order." Interview on 9/29/22 at 3:06 p.m. and on 10/3/22 at 3:41 p.m. with director of nursing (DON) revealed: *There had been no other documentation between 6/1/22 when the pain first presented until 6/3/22 when he was sent to the hospital. *Had expected a nurse to notify a doctor with his complaints on 6/1/22. *Had expected nurses to monitor and document in his medical record after his change on 6/1/22. *His catheter should have been changed and signed out on the TAR on 5/26/22. 2. Interview on 9/27/22 at 2:06 p.m. with resident 55 revealed she: *Was in her room in a bariatric bed. *Stated she had gone to the hospital this summer for treatment of a UTI. *Could not remember exact date. Record review for resident 55 revealed: *She had been admitted on 8/21/20. *She had a brief interview of mental status (BIMS) of 10, meaning she was moderately impaired. *Her diagnosis included: overactive bladder, indwelling catheter, UTI. *She was sent to the emergency room on 6/1/22 after a sudden change in condition. -Diagnosed with sepsis (acute), acute UTI, E. coli bacteremia and acute alteration in mental status. -Returned to the provider on 6/7/22. *Her revised care plan dated 6/9/22 revealed interventions for monitoring resident 55 for: -Risk for alteration of bowel and bladder functioning related to: --Foley catheter use.	F 684		

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F 684	Continued From page 58 --Obesity. --Impaired mobility. --Diuretic use. --Bowel incontinence. --History of UTI. -Catheter related trauma. -Catheter care every shift and as needed. -Change Foley catheter per facility protocol or MD order. -Monitor urine/catheter output every shift. -Monitor for pain/discomfort due to catheter use. Interview on 10/04/22 at 9:09 a.m. with regional nurse consultant X and DON B regarding resident 55's UTI/sepsis hospitalization revealed: *Her change in condition was a sudden onset of slurred speech and slow response. *The physician evaluated her while doing rounds and ordered her to be transferred to the emergency department. *The provider did update the care plan after this hospital stay to provide more guidance to staff. *Staff need to do a better job with peri care and re-education. 3. Observation and interview on 9/28/22 at 9:32 a.m. with resident 40 in his room revealed: *He had been sitting in his electric wheelchair. *A catheter bag had been hanging off a garbage can and the tubing had been lying on the floor of his bathroom. *The toilet had urine remaining in the bowl, and fecal matter spattered around the back half of the toilet and the toilet seat. *Stains had been noted on his bed mattress. *The front of his electric wheelchair had a thick layer of dirt. *His ostomy bag had been hanging below his shirt on the outside of his pants.	F 684		

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F 684	Continued From page 59 *Multiple bottles of personal hygiene products and empty boxes cluttered up his room. *He did not like people coming into his room to organize his stuff. Review of resident 40's electronic medical record revealed: *He had been admitted on 10/10/18. *He had a brief interview for mental status (BIMS) of 15, meaning he was cognitively intact. *His diagnosis included: personal history of malignant neoplasm of bladder, ostomy and urinary tract infection (UTI). *His revised care plan dated 7/13/21 revealed: -He preferred to provide his own ostomy cares. -He did not follow infection protocols as he has done this for many years. *He had been diagnosed with a UTI on 8/4/22. Interview on 9/28/22 at 3:39 p.m. with administrator A regarding observations of resident 40 revealed: *She had agreed his room does need to be reorganized. *He will only allow housekeeping in his room once a month. *She had agreed the catheter tubing laying on the floor would be an infection control issue. Interview on 9/28/22 at 4:21 p.m. with DON B regarding observations of resident 40's bathroom revealed she: *Had not been aware that his catheter bag and tubing had been stored in his bathroom. *Agreed that would have been an infection control issues. *Did not find any documentation that the provider tried to re-educate resident 40 on ostomy care.	F 684		

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F 684	Continued From page 60 4. Review of the provider's September 2019 Catheter Care procedure revealed: *The purpose of the procedure was to "prevent catheter-associated infections." *The catheter bag was to be positioned lower than the bladder to prevent urine from flowing back into the bladder. *To keep the catheter tubing and bag off the floor. *Residents who wanted to perform their own catheter care should be assessed to ensure they knew how to do it safely. *To notify the physician immediately with any signs or symptoms of urinary tract infection. 5. Observation on 9/28/22 at 5:40 p.m. of CNA R during supper service in the Warren dining room revealed she served coffee to resident 277 without thickening the beverage. Interview at that time with CNA R about resident 277 revealed she: *Did not know resident 277 had an order for nectar thickened fluids. *Did not "really know" the residents on the Warren unit. *Had seen resident 277's wife give him thin fluids previously, so she thought he could have thin fluids. *At that time, she retrieved the coffee, thickened it, and returned it to resident 277. Interview at that time with resident 277's wife revealed she: *Wondered why CNA R served coffee to resident 277 because both she and her husband were active Seventh-Day Adventists. *Discussed that Seventh-Day Adventists practiced certain dietary restrictions, such as refraining from drinking caffeinated beverages.	F 684		

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F 684	Continued From page 61 Please refer to tag F656, finding 6 for additional information regarding resident 277's religious dietary preferences. Review of resident 277's order summary report revealed: *He had a 9/12/22 physician's order for nectar thick fluids. 6. Observation and interview on 9/27/22 at 11:27 a.m. with resident 15 revealed: *"Sleeping in the wheelchair is not good, it hurts my tailbone." *He was "supposed to be getting a recliner" and the social service designee was working on it. *His right leg had an open area that was wrapped, and he reported he went to a wound doctor for it. *He had pain that was increasing, and he received two pills for pain, but he needed more. Review of the 7/12/22 admission Minimum Data Set (MDS) assessment for resident 15 revealed: *The pain interview assessment coded him as having occasional pain at a rating of five that "limited his day-to-day activities." *He had shortness of breath when lying flat. Review of resident 15's care plan revealed: *No interventions to obtain a recliner in his room to address his preference and need for comfort. (Refer to F656, finding 1.) *Pain focus area related to his leg wound, revised on 7/14/22, with interventions of: -Resident will report complaints of pain or requests for treatment. -The medication will have the "intended effect" or	F 684		

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F 684	Continued From page 62 the nurse will "notify the physician if interventions are unsuccessful." Review of the September 2022 medication administration record (MAR) revealed he received: *Three Gabapentin 300 milligrams (mg) capsules at bedtime for the non-pressure chronic ulcer on his lower leg, started on 9/2/22, (a medication used to manage pain due to damaged nerves). *Two Gabapentin 300 mg capsules two times a day for chronic venous hypertension with ulcer of his lower leg, started on 9/2/22. *Two acetaminophen 325 mg tablets every 4 hours as needed for pain, not to exceed 100 mg a day, started on 7/6/22. *One hydrocodone-acetaminophen 5-325 mg tablet every 6 hours as needed for moderate pain for non-pressure chronic ulcer of lower leg, started on 7/19/22. It was administered only on 9/28/22. An additional order on the September MAR revealed: *Staff were to "remind resident to elevate legs above the heart 3-4 times a day for 30-45 minutes and at night when in bed after meals and at bedtime related to generalized edema." *Documentation was present 4 times a day on 9/1/22 - 9/30/22 except for: -The 9:00 p.m. time on 9/2/22. -The 9:00 a.m. and 1:00 p.m. times on 9/26/22. Review of progress notes between 7/19/22 and 10/3/22 revealed: *No notation regarding an effort to obtain a recliner for resident 15. *A 9/2/22 progress note reported: -The order for three Gabapentin at bedtime was	F 684		

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F 684	Continued From page 63 an increased dose. -The resident "wants a different mattress - he feels like hes [sic] going to fall out of bed." Interview on 10/4/22 at 11:10 a.m. with SSD D revealed: *Resident had used a recliner at his previous long-term care location. *He did not have a bed in his room at that location. *She knew he wanted a recliner and was working on it but confirmed she had not written a progress note.	F 684		
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 ensure one of one resident (20) with a facility acquired pressure ulcer had received necessary care and interventions to prevent her wound from developing and worsening. Findings include:	F 686	1. Resident 20 will be assessed by a certified wound nurse on no later than October 26, 2022. Resident 20 is being checked for incontinence at least every two hours and repositioned at least every two hours. An advanced wheelchair cushion as been ordered to replace her current wheelchair cushion and resident is encouraged to lay down during the day for short periods to reduce the time she is sitting. Resident is being routinely bathed per her preference. 2. All residents with at risk for pressure injuries are at risk for developing pressure injuries and all residents that have pressure injuries are at risk for worsening pressure injuries. All residents with pressure injuries will be assessed by a certified wound nurse no later than October 26, 2022. All residents without pressure injuries but are assessed at high risk for pressure injuries and those with pressure injuries will have their care plans reviewed to ensure appropriate interventions are in place, including turning and repositioning, toileting schedules, bathing and incontinence care.	11/2/22

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F 686	Continued From page 64 1. Observation and interview on 9/27/22 at 4:02 p.m. with resident 20 revealed: *She had gone several weeks without a bath or a shower. *She could not recall the specific date but stated recently a staff person had assisted her into bed for the evening without changing her brief or removing her clothing. When she woke up in the morning, she was still in the same brief soiled with urine and stool and clothing. *She had been in her wheelchair since they had gotten her out of bed that morning around 10:00 a.m. *It was her normal routine to get up later in the morning around 10:00 a.m. and then be in her chair until the staff assisted her to lay down in the late afternoon or early evening. -She indicated staff usually would not check to see if she was dry, change her brief, or reposition her while she was up in her wheelchair. *In the evening when she was ready to lay down, at times it took up to two hours for staff to come assist her. She was often told 'just a minute' and then no one would come back to assist her. *After she was assisted into bed for the evening, the staff would usually come in between 9:00 p.m. and 10:00 p.m. to ensure her brief was dry, and then she did not get checked again until between 4:00 a.m. and 5:00 a.m. *Staff did not reposition her at night. *She did have a sore on her bottom and the nurses would put cream on it. Observation and interview on 9/28/22 at 3:39 p.m. with resident 20 revealed: *Staff had come in to change her soiled brief around 5:00 a.m. and then was not checked or changed again until she was assisted into her	F 686	3. The DON or Designee will educate all nursing staff on the following: Skin Program Policy and Interventions for residents at risk for pressure injuries and those who have pressure injuries (repositioning, offloading, toileting, incontinence care, bathing). The nurse will be educated on completion of the skin evaluations to ensure all areas are filled out and the evaluation is completed at least weekly. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The DON or designee will review all residents with pressure injuries each week to ensure skin evaluations are complete, including measurements, interventions are on the care plan and are being followed. Additionally, the DON will observe five random residents deemed at high risk for pressure injury development each week to prevention measures are care planned and being followed. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 686	Continued From page 65 wheelchair for the day around 10:00 a.m. *She had not been changed or moved since they put her into the wheelchair. *She did not know if her brief was soiled or not. Observation on 9/28/22 at 10:51 a.m. of resident 20 in her bed laying on her side while certified nursing assistants (CNA) N and AA performed perineal cares revealed: *Her coccyx was reddened with pinpoint open areas to her lower back on her coccyx. *Licensed practical nurse had come into the room with Calmoseptine cream and instructed CNA AA to apply a thin layer to the reddened open area. Review of resident 20's 7/16/22 significant change MDS revealed: *Her BIMS was 13, indicating her cognition was intact. *She was dependent on two staff for bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. *She was dependent on one staff for locomotion. *She could not walk and used a wheelchair. *She was always incontinent of bowel and bladder. *She was at risk for developing a pressure ulcer. *She did not currently have a pressure ulcer. *She did have moisture associated skin damage (MASD). *There had been a pressure reducing device for her chair and her bed. Review of resident 20's medical record revealed: *She had been admitted on 8/13/21. *She had been admitted with a stage II pressure ulcer to her right buttock that was healed on 7/29/22. *An order to apply Calmoseptine ointment to	F 686		

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F 686	Continued From page 66 buttocks twice a day due to incontinence of bowel and bladder. *6/19/22 at 12:11 p.m. a progress note indicated: "small of back with a indented are [area] with redness surrounding the indention..no visible open are [area] applied zinc oxide." -It had not indicated whether the physician was notified. *She had been hospitalized from 7/8/22 through 7/12/22. *She had returned from the hospital with fractures to both legs and an elbow. *Wound summary documentation indicated: -She had a stage I pressure ulcer on her low back: --6/22/22, measuring 4 centimeters (cm) x 5 cm. --7/8/22, measuring 3.8 x 4 cm. --7/22/22 and 7/29/22, measuring 2.5 cm x 1 cm. --8/19/22, measuring 2.2 cm x 1 cm. -On 9/19/22 the pressure ulcer was documented as healed. *On 7/12/22 in her readmission user defined assessment (UDA) had indicated she had no: -History of a pressure ulcer. -Existing pressure ulcer. *One 7/12/22 she had refused a skin assessment upon readmission due to complaints of pain. *The first skin assessment was completed on 7/25/22 and stated she had a red groin. *Her skin assessment on: -8/2/22 stated she had an alteration in skin integrity but did not indicate what it was or where it was located. -8/9/22 and 8/16/22 she had redness under breasts, left inner thigh, groin folds, and coccyx. -8/23/22 the skin on her coccyx was pink and irritated. Calmoseptine cream was applied. -8/30/22 her groin is red. -9/6/22 stated she had an alteration in skin	F 686		

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F 686	Continued From page 67 integrity but did not indicate what it was or where it was located. -9/14/22 stated she had an alteration in skin integrity but did not indicate what it was or where it was located. *No documentation of how often she was being repositioned. Review of resident 20's bathing documentation between 8/1/22 through 9/28/22 revealed she had: *Received a bath on 9/1/22 and 9/5/22. *Refused a bath on 9/22/22. -There had been no documentation of why or if another time had been set up to make up the missed bath. Review of resident 20's revised 7/21/22 care plan revealed: *She had "an actual impairment in skin integrity r/t CKD [related to chronic kidney disease]." *It had not indicated what the skin impairment was or where it was located. *Had a goal for her wound to not develop infection. *"Apply wound treatment as ordered by the physician." *"Encourage good nutrition and hydration in order to promote healthier skin." *"Keep skin clean and dry. Use lotion to dry skin." *"Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to MD [medical doctor]." *"Pressure reduction mattress and w/c [wheelchair] cushion." This was initiated on 2/25/22. *"Turn and reposition as needed." *It had not indicated she was at risk for pressure	F 686		

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F 686	Continued From page 68 ulcers or that she currently had a pressure ulcer. Interview on 9/28/22 at 3:54 p.m. with CNA AA regarding resident 20 revealed: *She usually worked a twelve hour day shift. *When she was working, they would get resident 20 up into her wheelchair around 10:00 a.m. or when she called for assistance. -This was the first time she had been changed or repositioned on the day shift. *Resident 20 would then stay in her wheelchair until she was ready to get into bed for the evening. *They did not check to ensure she was dry during the time she was in her wheelchair or reposition her. *Resident 20 was always incontinent of bowel and bladder and did not use the toilet. *Resident 20 did have a sore on her bottom. Interview on 9/28/22 with LPN BB regarding resident 20 revealed: *Resident 20 did have a pressure ulcer to her coccyx area and the nurses were putting cream on it. *She had thought all wounds in the building were measured weekly. *Had not been aware staff did not ensure resident 20's brief was clean and dry while she was up out of bed in her wheelchair. Interview on 9/29/22 at 4:11 p.m. with regional nurse consultant X revealed: *There was not a nurse designated as the wound nurse. *Director of nursing and Minimum Data Set nurse shared the role. *All pressure ulcers were to be measured weekly.	F 686		

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F 686	Continued From page 69 Interview on 10/3/22 at 4:00 p.m. with director of nursing B regarding resident 20's pressure ulcer revealed: *Interventions put into place were an air mattress, wheelchair cushion, keep skin clean and dry, and to turn and reposition as needed. *She thought the resident should have been repositioned every two hours. *She had not been aware resident 20 was not checked to ensure she was clean and dry while up in her wheelchair. *She had expected the staff at night to ensure she was clean and dry. *The pressure ulcer and her risk of developing a pressure ulcer should have been included in the care plan. *Resident 20's skin impairment was probably not related to her chronic kidney disease but from not being repositioned and being clean and dry. *They had not had a dedicated wound nurse, so the measurements of wounds were not getting done weekly. Review of the provider's April 2021 Skin Program revealed: *"To provide care and services to prevent pressure injury development, to promote the healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds." *A skin assessment should have been completed at time of readmission. *When a pressure ulcer was identified it was to be reassessed weekly, and provider was to be updated if not improving within two or three weeks. *"7. Nursing personnel will develop a plan of care (POC) with interventions consistent with resident and family preferences, goals and abilities, to	F 686		

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F 686	Continued From page 70 create an environment to the resident's adherence to the pressure injury prevention/treatment plan. *POC to include: Impaired mobility, Pressure relief, Nutritional status and interventions, Incontinence, Skin condition checks, Treatment, Pain, Infection, Education of resident and family, Possible causes for pressure injury and what interventions have been put into place to prevent. *Skin checks to be completed at least weekly by a Licensed Nurse." Review of the provider's September 2019 Care Planning policy revealed each resident's care plan should be updated to reflect their current needs.	F 686		
F 689 SS=D	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, record review, and policy review, the provider failed to investigate a fall incident from sit-to-stand lift for one of four sampled residents (36). Findings include: 1. Interview with resident 36 on 9/29/22 at 11:24 a.m. during the resident group meeting revealed: *She was positioned up to a dining room table	F 689	1. No immediate correction could be made for Resident 36's unreported allegation that CNAs have been too rough with her and hit her foot during transfers in the past or for Resident 36's event in which she was lowered to the floor from the lift on 3/26/22. Resident will be interviewed to ensure recent care has been free from perceived roughness and hitting her feet during transfers. Resident will also be reminded to report any problems with her care to the charge nurse, DON or Administrator. Resident 36's care plan was updated to include how resident transfers. 2. All residents are at risk for sustaining an injury during cares or during an intercepted fall. All resident's care plans were reviewed to ensure transfer status is on the plan of care. 3. The DON or Designee will educate all nursing staff on the Fall Management Policy and what constitutes a fall, ensuring care is provided in a non-hurried manner so that injury can be avoided, and that no cell phone use is permitted while caring for residents.	11/2/22

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F 689	Continued From page 71 while seated in a wheelchair with her feet positioned on foot pedals. She said the certified nursing assistants (CNAs) "have been too rough when lifting me and have hit my foot during transfers." *When asked if she had let anyone know about that, she replied, "They just disregard that and make into big deal." *One CNA was "talking on his phone while taking care of me." *Another time, "the sling was not fully attached," but her fall was reported as "me having sat down instead." Interview on 10/04/22 at 11:04 a.m. with director of nursing B and regional nurse consultant X revealed: *The incident of her sitting down should have been reported and investigated as a fall. *They review the record for fall documentation and provide if anything was found. Review of the admission lift evaluation on 3/22/22 for resident 36 revealed: *She was unable to "stand, pivot, & [and] walk with no assistance or with limited assistance" and "bear at least 50% [percent] on at least 1 leg." *The type of lift required was a sit to stand. Review of resident 36's electronic health record revealed a general progress note dated 3/26/22 that noted: *Licensed practical nurse (LPN) L was "called to resident's room by [CNA M]." *"Resident [was] sitting on the floor with her back against the bed." *CNA M and "resident state that there was no fall." *CNA M lowered the resident "to the floor to	F 689	The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The DON or designee will interview five random residents to ask if staff are careful and not rushed during cares. The progress notes of five random residents will be reviewed to ensure there is no documentation of intercepted falls that are not counted as an actual fall and five random resident care plans will be reviewed to ensure transfer status is included on their care plan. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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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 689	Continued From page 72 prevent her from sliding out of the sling on the stand assist." *The progess note included checkmarks so that it would "show on the Shift Report" and "Show on the 24 Hour Report." A review of the user defined assessments (UDA) completed since the admission date of 3/22/22 did not reveal a fall risk evaluation following the 3/26/22 progress note. Comparative review of the 3/28/22 admission Minimum Data Set (MDS) and the 9/15/22 quarterly MDS for resident 36 revealed: *Her admission date was 3/22/22. *The 3/28/22 admission MDS coded "none" as the number of falls since admission. *The brief interview for mental status revealed she was cognitively intact with no behavior symptoms. *For the activities of daily living (ADL) task of transfer, she required non-weight bearing assistance of one person on 3/28/22 and then weight-bearing assistance of one person on 9/15/22. *For the ADL of toilet use and transferring on and off the toilet, she required non-weight bearing assistance of two persons on 3/28/22 and the weight-bearing assistance of one person on 9/15/22. *Walking in her room occurred once or twice with two persons assist on 3/28/22 and then did not occur on 9/15/22. Review of resident 36's care plan revealed: *The focus for "assistance with ADL's" revised on 4/24/22 included interventions: -Initiated on 3/22/22 to "Provide DME [durable medical equipment] if needed (wheelchair, cane,	F 689		

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	435039	A. BUILDING _____ B. WING _____	C 10/04/2022

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F 689	Continued From page 73 walker, etc.)," but there was no intervention to use a sit-to-stand lift for transfers, except: -Initiated on 7/1/22 for a "restorative nursing programs" for "transfers-sit to stand 10 reps, safety training." Review of September 2022 task documentation for transfers revealed she required weight-bearing physical assistance from one person most of the time that task occurred. Four times there were two persons who assisted. Review of the provider policy dated November 2019 for "Falls Management" revealed: *The fall definition included: -"A fall is the unintentional change in position coming to rest on the ground, floor or onto the next lower surface (e.g., [example] onto a bed, chair, or bedside mat)." -"An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not intercepted by another person - this is still considered a fall." *The "Procedure upon Admission/Readmission" included: -"Implement goals and interventions with resident/resident representative for inclusion in the Plan of Care based on individual needs and identified risks." -"Communicate interventions to the caregiving teams." *"Post Fall/Injury Resident Management" included the nurse was to complete a "quick head-to-toe scan" and obtains "vital signs" and enters that data into "Risk Management." *"Fall Injury Prevention - Post Fall" included: -"Complete Fall Risk Evaluation 1.5 UDA." -"Complete Pain Assessment 1.1 Version 2 UDA."	F 689		

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F 692 F 692 SS=J	Continued From page 74 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §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 maintenance of hydration status for one of one resident (16). Findings include: 1. Observation and interview on 9/27/22 at 9:59 a.m. revealed resident 16: *Was in bed with the head of the bed raised and an overbed table on wheels positioned in front of her. A big water mug with a straw was on the overbed table. *Had patches of flaky skin on her lips and teeth appeared dull with yellow build-up and dry.	F 692 F 692	1. Resident 16 assessed for signs and symptoms of dehydration. Resident 16 had abdominal assessment including bowel sounds. Resident 16 orders reviewed. Resident 16 was interviewed for beverage preferences. Resident assessed by dietitian. 2. All residents are at risk for dehydration. All residents were assessed for signs and symptoms of dehydration on September 30,2022. If not already on, Intake monitoring was implemented for hydration improvement. 3. Immediate Education was provided on September 30, 2022 to C.N.A.'s, Dietary Aides, Cooks, and Nurses regarding importance of hydration, and fluid intake of all residents, signs, and symptoms of dehydration, and on amount of mL's in each beverage container. They were provided a list of high-risk residents. C.N.A.s and nurses were educated regarding importance of bowel documentation and follow up on October 3, 2022. C.N.A's, Dietary Aides, Cooks, and Nurses will be re-educated by November 2, 2022. C.N.A.'s, Dietary Aides, Cooks, and Nurses who are on vacation, prn, sick leave, etc will be educated upon their return. 4. Audit 12 resident's intake, oral care, and bowels daily x 4 weeks, 3x week x 4 weeks, weekly x 4 weeks, monthly x4 months. Water pass audit daily x4 weeks, 3x week x4 weeks, weekly x4 weeks, and monthly x4 month. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	11/2/22

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F 692	Continued From page 75 *Moved her arms about in uncontrollable jerking movements. *Spoke with a muffled sound and moved her lips only slightly when she confirmed that she received enough to drink throughout each day. Observation on 9/27/22 at 12:10 p.m. revealed resident 16 was seated in a high back wheelchair in the dining room being fed by a certified nursing assistant (CNA). Interview on 9/28/22 at 3:51 p.m. with CNAs S and V revealed: *They were assigned to work on resident 16's wing that day for a twelve hour shift starting at 6:00 a.m. *CNAs were responsible for picking up water mugs from resident rooms and delivering fresh water in clean mugs to resident rooms. *They had "not had time today" to do that. Observation and interview on 9/28/22 at 4:26 p.m. with resident 16 revealed: *Her lips did not have flakes of skin but were pale in color and dry and her teeth remained dull and dry. *A smaller white plastic water mug full of water with a straw was in front of her on the overbed table. *She was unable to state what time it had been provided. Interview on 9/29/22 at 10:00 a.m. revealed the seven residents who attended a resident group meeting at that time agreed they received fresh ice water when they "ask for it," but it was not routinely delivered "without asking." Observation on 9/30/22 at 10:10 a.m. of resident	F 692		

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F 692	Continued From page 76 16 revealed: *She was in bed sleeping. *Her lips were pale, dry, and rough. *Eight ounces (oz) of water in a 9 oz white plastic water mug with a straw was on the overbed table. Interview on 9/30/22 at 10:12 a.m. with CNA S revealed: *She and the other CNA assigned to the wing had "not passed fresh water yet." *She reported resident 16 was able to pick up her water mug and drink from the straw. Review of resident 16's electronic health record (EHR) revealed: *Her entry date was 1/26/21 with diagnoses including multiple sclerosis, Hemiplegia and hemiparesis, neuromuscular dysfunction of bladder, chronic pain syndrome, and major depressive disorder. *The care plan included: -An intervention initiated on 2/10/21 to "encourage adequate fluid intake" that addressed the goal for no urinary tract infections related to her previous history of UTIs and use of a suprapubic (SP) catheter. -An intervention revised on 7/26/21 to "report to the nurse any signs and symptoms of discomfort on defecation and frequency" related to her risk for "alteration of bowel...related to...always incontinent of bowel." -A focus for use of antidepressant medication, Remeron (mirtazapine), initiated on 9/17/20 and "resolved" [removed] on 8/2/21, with an intervention to "monitor/document side effects...dry mouth, dry eyes, constipation, urinary retention." -Two focus areas revised on 6/15/22 that did not include interventions for how staff would ensure	F 692		

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F 692	Continued From page 77 adequate hydration related to: --Required assistance with activities of daily living (ADL) due to hemiparesis, including the ADL of eating. --Potential for altered nutritional status due to multiple sclerosis. One intervention stated, "I like iced coffee with my meals with extra cream and sugar." *The September 2022 medication administration record (MAR) revealed the following orders: -On 1/28/21, "monitor for dry mouth, constipation"... and other potential side effects related to antidepressant use. Both day and evening shifts were documented (except for three blank shifts) with a checkmark instead of as directed: "Document: 'Y" if monitored and any of the above observed. 'N' if monitored and not of the above was observed." -On 3/4/21, mirtazapine 30 mg [milligrams] by mouth at bedtime for depression. -On 3/23/21, polyethylene glycol 3350 powder 17 gram by mouth as needed every 24 hours for constipation. It was not recorded as being given on any day during the month. -On 11/4/21, Ditropan XL extended release 24 hour 15 mg, "give 1 tablet by mouth one time a day" to treat muscle spasms. According to Drugs.com, Ditropan is used to treat symptoms of an overactive bladder and may cause side effects including constipation, dehydration, and dry mouth. -On 11/13/21, Bisacodyl tablet delayed release 5 mg "give 10 mg by mouth one time a day for constipation." *The most recent quarterly dietary evaluation, dated 2/2/22, noted: -She had functional problems and needed significant physical assistance to eat. -No evaluation of lab values.	F 692		

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F 692	Continued From page 78 -An average intake of fluid at 1500-2000 milliliters (mL) daily. *Comparative review of the 11/2/21 annual Minimum Data Set (MDS) assessment and the 7/8/22 quarterly MDS noted the following declines: -The brief interview for mental status scored her as cognitively intact then moderately impaired. -The mood interview coded her as reporting no symptoms then "feeling tired or having little energy nearly every day." -Her upper extremity range of motion limitation was coded as just one side then on both sides of her body. -Her bowel status was coded as occasionally incontinent with no constipation to having constipation present. Review of communication records in resident's 16's EHR over the past three months revealed ongoing concerns with irrigation of the catheter, urinary tract infections, and skin breakdown, as follows: *A discharge record dated 7/17/22 from the emergency room (ER) noted a clinical impression of obstructed SP and UTI with instructions for an antibiotic twice a day for three days and "push fluids." *Progress notes on 7/18/22, 7/22/22, and 8/2/22 addressed insurance denial, a physician order for use of Renacidin, a catheter irrigation solution, and to use "30cc NS [normal saline] TID [three times a day] as an alternate. *A urology consult on 8/3/22 at 3:49 p.m. ordered "irrigate SP catheter PRN [as needed] with 60 cc's [cubic centimeter] of sterile water and a 60 cc cath [catheter] tip syringe if catheter is plugged." *A telemedicine consult on 8/3/22 at 4:28 p.m. noted the SP catheter was plugged and licensed	F 692		

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F 692	Continued From page 79 practical nurse (LPN) L could not clear it with irrigation with an order request to send to the ER. *A nursing progress note on 8/21/22 at 4:24 p.m. reported, "This am [before noon] prior to Renacidin Foley flush cna reported res [resident] peri [private] area very red with yellow discharge....also reported res bypassing urine. Writer also observed res urine coming out of cath insertion site. Attempted to flush cath with renacidin which was a very hard flush. Only small amount went through actual catheter. Flushed cath with ns, then repeated renacidin clamped for 20 min. When disconnecting cath tubing for flush, res urine very thick like maple syrup, and slimy. Urine dark amber color, with very foul odor. Spoke with res about needing to increase fld [fluid] intake, and educated cna as well." *A faxed order on 8/22/22 directed 1500 cc [cubic centimeters] fluid per day, "Please write a schedule & [and] make sure this is getting done" and "check UA [urinalysis] w/C&S [with culture and sensitivity]." *An order was entered on 8/22/22 to give 500 mL of fluids TID. *A note faxed on 8/23/22 to the physician reported an "open area to L [left] buttock cheek crease" with an order to treat. *Two progress notes on 8/25/22 at 10:39 a.m. and 2:50 p.m. reported, "catheter flushes unsuccessful and continues to bypass urine" followed by a clinic appointment with a new catheter inserted and orders for next SP catheter change on 9/22/22. *Two progress notes on 9/2/22 reported: -At 10:53 a.m., the urine was "completely bypassing catheter and [resident] is lying in urine from shoulders to knees. Sediment packed into catheter tubing and unable to flush with renacidin x 2. resident reports that catheter rarely flushed	F 692		

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F 692	Continued From page 80 and has not been flushed in at least three days. some sediment loosened in catheter but unable to unpack. resident reports discomfort." -At 4:36 p.m., an order to obtain a UA and "flush 2-3x [times] daily with renaciden (sic) to break down sediment." *A faxed note from the laboratory on 9/6/22 noted, "urine sample contaminated. Is patient symptomatic? If symptomatic, collect urine sample again." *A progress note dated 9/8/22 reported urology orders related to UA for Nitrofurantoin [antibiotic] 100 mg [milligrams] bid [two times a day] for 3 weeks. *A progress note dated 9/21/22 reported "MASD [moisture-associated skin damage] area to right gluteal [buttock] fold." Review of monitoring records in resident 16's EHR revealed: *The most recent basic metabolic laboratory (lab) report was dated 4/25/22. No further lab results were completed to evaluate her electrolyte balance. *No documentation to indicate a clinical review of her fluid intake was completed to ensure she was receiving adequate fluid intake. *The daily fluid intake records for August and September 2022 had multiple days and times of intake not documented making it difficult to determine actual fluid intake every day and verify that the 1500 cc per day had been met. On the days that were recorded, the intake averaged: -During meals, recorded on 15 days in August and 14 days in September, had an average of 397 mLs fluid per day. -Between meals, recorded 15 days in August and 15 days in September, had an average of 359.67 mLs fluid per day.	F 692		

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F 692	Continued From page 81 *The daily bowel record noted bowel movements (BM) on only five days in August (8/2/22, 8/9/22, 8/15/22, 8/23/22, and 8/31/22) and five days in September (9/12/22, 9/13/22, 9/19/22, 9/26/22, and 9/28/22) with the condition of constipation on 9/13/22 and 9/19/22. *The September 2022 MAR noted no checkmarks to indicate orders were administered as started: -On 9/30/21, "Flush supra pubic catheter with 10 mL normal saline TID PRN as needed for increased sediment." -On 10/31/21, "Flush suprapubic catheter if not draining PRN as needed for flush." -On 11/19/21, "Indwelling Catheter Type: Suprapubic, Catheter Size: 16F, 10 CC balloon. Change on the 23rd of the month and PRN as needed for leaking or dislodgement. -On 8/3/22, "Irrigate SP catheter PRN with 60 CC of sterile water and 60 CC cath tip syringe if catheter is plugged." *The MAR noted administration for each day in September 2022, except for four blank times, of "Renacidin Irrigation Solution (Citric Acid-Gluconolactone-Magnesium Carbonate), Use 1 vial via irrigation three times a day" started on 9/2/22. Interview on 9/30/22 at 9:30 a.m. with dietary manager (DM) F, while reviewing resident 16's 9/30/22 dietary meal tickets revealed she would be offered: *No fluids for breakfast. That meal was marked in large bold letters, "Do Not Serve" DM F stated it was her preference to sleep in during the morning and not be served breakfast. *One cup, 8 fluid ounces (fl oz) or 237mL, of fluids at lunch *Two cups, 16 fl oz or 474 mL, of fluids at supper.	F 692		

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F 692	Continued From page 82 IMMEDIATE JEOPARDY HARM Observations and interviews of resident 16 on 9/28/22 through 9/30/22 revealed she had dry, chapped lips with flakes of loose skin, dry mouth when she spoke, and her teeth were dull with yellow buildup. She required extensive assistance of one person to eat and drink. Her EHR revealed she has a suprapubic catheter that required two visits to the ER on 7/17/22 and 8/3/22 due to complications from a blocked catheter tube and large amounts of sedimentation. A health status note from 8/21/22 indicated she was bypassing the catheter, urine was coming out of catheter insertion site, they attempted to flush renacidin irrigation solution, very hard flush, they disconnected the catheter tubing for the flush, urine was very thick (like maple syrup, slimy, dark amber color, very foul odor). An order on 8/22/22 for a fluid goal of 1500 cc per day and to "write a schedule and make sure that this is getting done" was entered as an order to give 500mL of fluids TID; however, August and September 2022 fluid intake documentation was inconsistent with multiple days' worth of fluid intakes not documented making it difficult to determine actual fluid intake every day. The registered dietitian had not assessed her nutrition status since February 2022, and it did not include a fluid intake assessment. No other documentation was found in her record to indicate clinical review of fluid intake to ensure she was receiving adequate fluid intake. Lab results for the last six months revealed no labs had been obtained to evaluate her electrolyte balance. Bowel records showed she had only 5 movements in September 2022 with two times recorded as constipation. Random observations made by surveyors from 9/27/22 through 9/29/22 revealed staff do not pass fresh	F 692		

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F 692	Continued From page 83	F 692		

water to residents on a regular basis. Interviews with staff and residents confirmed those observation.

IMMEDIATE JEOPARDY NOTICE
On 9/30/22 at 11:15 a.m., administrator (ADM) A, director of nursing (DON) B, and regional nurse consultant (RNC) X were requested to provide a plan for removal of the immediate jeopardy that had been determined due to the provider's failure to have systems in place to monitor and ensure resident 16 received adequate hydration per orders placing her at increased risk for negative outcomes, including fluid and electrolyte imbalance, frequent ER visits due to thick urine, frequent UTIs, common symptoms of constipation, continued skin problems, and poor dentition.

IMMEDIATE JEOPARDY REMOVAL PLAN
On 9/30/22 at 1:21 p.m., ADM A, DON B, and RNC X provided an acceptable removal plan, "Ad Hoc QAPI [quality assurance performance improvement]," which included:
"1. Immediate corrective action for those affected by the deficient practice:
*"9/30/22 at 11:55AM Resident #16 was assessed for signs and symptoms of dehydration by [name] DON. Suprapubic Site no evidence of urine leakage, no redness, no warmth. Dressing changed, clean, dry, and intact on 09/30/22. Urine amber colored, and dense. Oral membranes were moist, tongue was moist, eyes were moist, lips were dry and cracked. Skin turgor appropriate. Skin turgor did not show tenting. Resident #16 Primary Care Provider was contacted on 09/30/22 at 12:15PM, left message, returned call at 1:00pm and ordered basic metabolic panel and continue to monitor.

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F 692	Continued From page 84 *"Reviewed Resident #16 Order for 1500mL per day fluid goal, schedule as follows, Morning water pass minimum of 200mL, Lunch minimum of 420mL, Afternoon water pass 240mL, Supper minimum of 420mL, NOC [night] shift minimum of 260mL. *"Schedule posted on Dietary Wall, in C.N.A. and Nurse Communication book, and at Center Nurses station. *"Resident #16 will be interviewed for preferences of beverages she prefer to consume. *"Resident #16 Oral care will be provided 3x day by C.N.A. or Nurse. *"Resident #16 Nurses will complete abdominal assessment for bowel sounds, and ensure abdomen is soft and non-tender 2x week to assist with signs and symptoms of constipation. Nurses will follow bowel protocol to ensure PRN medications are administered as ordered to assist with prevention of constipation and ensuring appropriate hydration status. *"Resident #16 will be assessed by Dietitian on 10/04/2022. *"Resident #16 Care Plan will be updated to reflect the above. "2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: *"All other residents will be assessed for signs and symptoms of dehydration. If not already on Intake monitoring will be implemented for hydration improvement. *"Immediate Education will be provided to C.N.A.'s, Dietary Aides, Cooks, and Nurses regarding importance of hydration, and fluid intake of all residents, signs, and symptoms of dehydration, and on amount of mL's in each beverage container. They will be provided a list of high-risk residents to ensure awareness of fluid	F 692		

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	435039	A. BUILDING _____ B. WING _____	C 10/04/2022

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F 692	Continued From page 85 consumption. C.N.A.s and nurses will be educated regarding importance of bowel documentation and follow up. *"Nurses will have a task on the TAR for monitoring fluid consumption of high-risk residents prior to end of shift, to ensure minimum goal of fluids has been consumed. *"Water pass was implemented at 10:30AM on 09/30/22. "3. Measures put in to place/systematic changes to ensure the deficient practice does not reoccur *"Nurse Manager will be assigned to observe, monitor, and ensure hydration schedules are being followed, and oral care is completed. *"Will review fluid intake and BM documentation daily during morning clinical meeting. "4. Plan to monitor performance to ensure solutions are sustained *"Audits 12 resident's intake, oral care, and bowels daily x 4 weeks, 3x week x 4 weeks, weekly x 4 weeks, monthly x 4 months. *"Water pass audit daily x4 weeks, 3x week x4 weeks, weekly x4 weeks, and monthly x4 months. IMMEDIATE JEOPARDY REMOVAL REVIEW On 10/03/22 at 12:45 p.m., the survey team requested documentation to verify what was done for removal of the immediate jeopardy. Documentation provided by ADM A and RNC X and reviewed by the survey team revealed: *Resident 16 was interviewed on 9/30/22 at 4:30 p.m. (the name of the interviewer was blank), which revealed: -She reported she felt she got enough fluid. -Her preferences included water and chocolate milk. -She reported having a bowel movement "3 days ago" when asked, "Have you had difficulty with bowel movements?"	F 692		

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F 692	Continued From page 86 -She had no concerns with her catheter, going to the bathroom, or with staff. *A one page large print plan for resident 16's "Fluid Expectations" including: -"AM Water Pass: 180mL per day -"Lunch: 420mL per day -"Afternoon Water pass: 360mL per day. -"Supper: 420mL per day. -"NOC shift: 360mL per day" *Resident 16's care plan had not been revised to reflect these fluid expectations. *Hydration Documentation Education" was completed with "Hydration, Constipation, and Dehydration" quizzes for numerous staff dated 10/1/22. *Audits had been started to monitor for: -"Water pass completion" through resident interviews and observation of three planned water pass times. -Fluids received, consumed, and documented at meal time and afternoon snack time for 12 random residents per day. -BM documentation completed, abdominal assessment when tree days had passed without a BM, and bowel protocol followed for 12 random residents per day. *A list of high risk residents was prepared for staff to ensure "accurate and entered timely" fluid documentation. *A "Room Roster" form that included all residents with rows and columns to record mL amounts of AM, PM, and NOC fluid intakes. Documentation on 10/2/22 and partial documentation on 10/3/22 were the same amounts for all residents. Observation and interview on 10/3/22 at 12:47 p.m. with resident 16 revealed: *She was sitting up in her chair in her room. *Her teeth were yellow but shiny.	F 692		

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F 692	Continued From page 87 *Her lips were moist with a pale pink color. *Her speech sounded more fluid. Interview on 10/3/22 at 1:40 p.m. with ADM A and RNC X revealed: *They agreed that staff had documented on the Room Roster for all residents how much fluid was offered not consumed and the staff will need further education. *When asked about who was responsible to ensure the care plan was updated, they indicated -It was a team effort. -They thought DON B had updated the care plan to reflect the current changes for resident 16. -They were not aware it had not been updated. Interview and review of revised documents on 10/3/22 at 2:44 p.m. with ADM A and RNC C revealed: -A "Staff In-Service Sheet" documented attendance by staff on 10/3/22 for "additional hydration education." -The Room Roster intake documentation sheet had been revised to record AM, PM, and NOC amounts "offered" and "consumed." -Resident 16's care plan had been revised on 10/3/22 to include, "Encourage and help the resident drink at least 1,500 cc's of fluid each day. 15cc's per pound of body weight is recommended (140 pound person should drink 2,100cc's per day)." On 10/3/22 at 2:57 p.m., the survey team notified ADM A and RNC X that the immediate jeopardy was removed, and the remainder of the survey would continue.	F 692		
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)	F 725		

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F 725	Continued From page 88 §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and facility assessment review, the provider failed to ensure sufficient nursing staff were available to provide nursing services to meet residents' needs safely and in a manner that promoted each resident's rights and physical, mental, and psychosocial well-being for 79 residents. Findings include:	F 725	1. No correction could be made to the unidentified resident. Resident 45 is getting bathed per his preference. Resident 61 is being toileted in a timely manner. Resident 40 is being assisted in a timely manner. CNA S received orientation. Resident 63 is being transferred as he desires. The facility assessment has been updated and reviewed by the Regional Director of Operations. 2. All resident are at risk for not receiving needed cares and assistance. Residents have been educated on how to file a grievance and/or a complaint with the SD DOH. The Administrator and/or DON will perform walking rounds each day Monday through Friday on various shifts to ensure cares are being completed timely and resident needs are being met. 3. Recruitment efforts are ongoing with various advertising mediums, referral bonuses sign-on bonuses and shift bonuses are offered. Staffing Agencies are employed to supplement The Administrator or designee will educate staff on ensuring timely cares and asking for help when needed and reminding all staff that they can answer call lights. Additionally, the HR director will be educated that all staff must receive orientation prior to performing resident cares. The education will occur no later than November 2, 2022, and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The Administrator and/or DON will review the staffing levels each day. The Administration and/or DON will perform walking rounds each day Monday through Friday on various shifts to ensure cares are being completed timely and resident needs are being met.	11/2/22

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F 725	Continued From page 89 1. Interview on 9/27/22 at 4:02 p.m. with a resident who did not want to be identified revealed: *She did not get a bath regularly. *She had false teeth, staff did not usually brush them, they just put them in a denture cup at night with a denture cleaning tablet, rinse them off in the morning and give them back to her. *Hates the weekends because staff is always short and feels there is no one there to care for her. *Sometimes in the evening when she is ready to get into bed, she has to wait up to two hours for assistance. -She states usually because it takes two staff to transfer her and there is not always two available to help. *She stated the staff will tell her "just a minute" but then never come back. *Has been put to bed at night soiled and not changed until the next morning. 2. Interview on 9/27/22 at 4:53 p.m. with resident 45 revealed: *At times he has to go without a shower because there is not enough staff to assist him with the task. *He stated "This [the provider] is a business and its about meeting the business standards, not taking care of people." *He did not think management listened to what the residents wanted or needed. 3. Interview on 9/27/22 at 4:21 p.m. with resident 61 revealed she: *Had been sitting in her wheelchair in her room. *Had to wait a long time to use the bathroom. *Had some accidents because she has to wait for	F 725	The weekend manager on duty will perform the walking rounds each Saturday and Sunday. During the walking rounds, five random residents will be asked if their care needs are being met in a timely manner. Walking rounds and staffing levels will continue daily for three months. Results of walking round audits and staffing levels will be discussed by the Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings	

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F 725	Continued From page 90 someone to transfer her. Record review for resident 61 revealed she: *Was admitted on 6/20/19. *Had a diagnosis of unspecified urine incontinence. *Was assessed on the Minimum Data Set (MDS) dated 8/26/22 as one person physical assist with transfers. 4. Interview on 9/28/22 at 9:07 a.m. with resident 40 revealed he: *Had been sitting in his electric wheelchair in his room. *Had to wait 30 minutes in the morning for help sometimes. *Stated "staff take other residents to the dining room to eat and then do not come back to help him." Record review for resident 40 revealed he: *Was admitted on 10/10/18. *Had a diagnosis of malignant neoplasm of bladder and a Urostomy. *Was assessed on the MDS dated 7/18/22 as one person physical assist with transfers. 5. Interview on 9/27/22 at 3:15 p.m. with certified nursing assistant (CNA) M, who was assigned to give baths that day, revealed: *She did not know where she would be assigned until she arrived that morning, but she was okay with giving the residents baths, because she knew they would get done. *She had been full-time but worked just part-time now because of the concerns she had identified with poor quality of care, including: -Perineal care not getting done correctly leading to a high frequency of urinary tract infections.	F 725		

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F 725	Continued From page 91 -Oral care not getting done at all. -Not all of residents were getting routine baths or showers. -Not using two staff when total lifts were used. *She was trying to get as many baths done as she could to get some of the missed residents done. *The tub room was a mess when she first walked into it that morning with soiled towels all over the place. *She named several residents who have had negative experiences related to staffing concerns. 6. Interview on 9/28/22 at 3:51 p.m. with CNAs S and V revealed: *CNA V had been working here for a few weeks, but CNA S started just on Monday, 9/26/22; both were already CNAs when they started. *CNA V reported she had received "a little" orientation when she started, but CNA S said she had received "none." *They were assigned to work two halls together, blue [rooms 218-230, 20 residents as of 9/27/22] and red [209-217, 15 residents as of 9/27/22], but sometimes there was only one CNA for the blue wing. *No help was provided from "other staff or nurses." *They did not know who leadership was. *There was "no rounding between shifts" with the off-going CNAs. *They "try hard" to do all personal cares." *The bath CNA "doesn't do any baths outside of scheduled baths." *The CNAs "have to pick up the water cups from each room and return with fresh water during the shift." CNA V reported there was no system for doing that when she first started so she started putting tape on the mugs so she could tell when	F 725		

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F 725	Continued From page 92 fresh water was last delivered to each room. *Snack carts had to be done by CNAs if it was going to be done. *They had not had time yet to pass fresh water or snacks. Review of the employee files for CNAs S and V revealed: *CNA V started on 9/15/22 and there was a completed orientation checklist in her file. *CNA S started on 9/26/22 but there was not a completed orientation checklist in her file. Interview on 10/4/22 at 1:15 p.m. with human resource director (HRD) H revealed: *CNA S had not received orientation because she "started working before she [HRD H] knew she was starting. *CNA V "resigned effective immediately" last week. 7. Interview on 9/28/22 at 4:16 p.m. with CNA N, while standing at the nurses desk with no residents in the area, revealed: *She had worked as a CNA here for a year. *The CNAs rotate wing assignments, and it took her "two weeks to get to know every resident." *She was assigned as bath CNA that day, but they "usually don't know who is assigned" until they come on duty. She was the bath CNA "maybe once a week out of three to four days. *The day shift CNAs will do "walking rounds" with the night CNAs if the "night CNAs get here on time." *The CNAs do not get report from the nurses. *Regarding the bath schedule: -There is a schedule in the tub room. -The CNAs fill out a "bath sheet to report the bath being done and any concerns observed during	F 725		

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F 725	Continued From page 93 the skin check." -If scheduled bath is not done, "a second CNA may see if the resident is willing" to get a bath that day. -If the bath is not done, it may be done on another day "if there is time and the bath CNA is aware of who was not done." -"Sometimes, the nurse will write a note in the bath book." -We document the bath task in POC [point of care]. *"Radios don't help" with communication between staff. There was "either not enough or they are not charged." *The CNAs are "not able to hear call lights from one end to the next." *Most "Hoyer [total] lifts are on blue [wing]", and the "CNAs have to pool together to get two person transfers done." *Mealtimes can be a challenge for assisting all the residents. -"Today during lunch, there wasn't enough. Several people, including leadership, left while the surveyors were gone for lunch." -"Supper is hardest" for having enough staff to assist with the mealtime because "we are changing shifts at 6:00 [p.m.]" At the end of the interview with CNA N on 9/28/22 at 4:20 p.m., LPN L, who was charting while seated at the nurses desk, spoke up and reported there was "never enough staff." She said, "Management has asked the CNAs several times what would help, and nothing has changed." 8. Interview on 9/29/22 at 10:00 a.m. with 7 residents (9, 34, 36, 50, 52, 63, and 73) interviewed during the resident group meeting agreed:	F 725		

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F 725	Continued From page 94 *They did not know who to go to when reporting a grievance. There had been "so many changes in the last two months" that they "don't know what is happening." *The provider did not have sufficient staff to ensure care was provided in a timely manner: -They reported they have had to "wait too long for call lights to be answered. -Staff get "pulled away when providing care" with a resident, "sometimes several times," to help with other situations. -At times, there will be two staff when using a mechanical lift but "usually only one." -The CNAs "stand at the desk or in the hallway talking and laughing with each other while call lights are going off." -Resident 34 had "reported that [when CNAs were not responding to call lights] to the nurse, but "no changes in behavior" have been seen. -Resident 73 reported he "sat on toilet today for an hour before a medication aide arrived" and then she did not want to take the time to get the sit-to-stand lift. When he refused, she said, "I'm the boss, we'll do it my way." (Refer to F600, finding 2.). -Resident 63 reported "staff will not transfer me more than once a day" so, when he wanted to attend morning and afternoon activities, he had to choose so he could get off his wheelchair during the day. -Residents 9, 34, and 63 all agreed they have had to help other residents "get over a doorway threshold when stuck" because there were no staff around to help. Then they get told they were not supposed to help other residents but "do not get an explanation for why." -"This should be our home, but it isn't." -"They treat us as just a reason to get a paycheck."	F 725		

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F 725	Continued From page 95	F 725		

*They got fresh ice water when they "ask for it," but it is not routinely distributed.
*They had not seen a snack cart and had never been offered snacks at bedtime.

9. Review of the Facility Assessment revealed it was dated 5/24/21 and was based on an average daily census of 52 residents.

*The facility census on the 9/27/22 Resident List Report had 79 residents total, with:.
-20 residents on "Unit: 218-230 Blue (Center)."
-16 resident on "Unit: East-Wing" [rooms 301-312].
-15 residents on "Unit: 209-217 Red (Center)"
-12 residents on "Unit: 201-208 Yellow (Center)."
-16 residents on "Unit: Warren Wing [rooms 100-115]."

*Comparative Review of the staffing numbers posted on the dry erase board in the conference room and the August and September 2022 nursing schedules revealed:
*The "current census" was listed on the board as "80, 18 [short stay]" residents. The "goal census" was "80, 20."
*The CNA numbers on the board listed eight CNAs, without specifying which shift, assigned as:
-CNAs "Blue x [times] 2.
-East x 2.
-Red/Yellow [both wings] x 1.
-Bath aid x 1.
-Warren x 1.
-Warren/Red x 1."
*The August and September 2022 schedules revealed:
-On 9/6/22 and 9/7/22, there was only one CNA.
-On 9/13/22, there were only three CNAs.

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F 725	Continued From page 96 -On 8/28/22 - 9/1/22, 9/3/22, 9/11/22, and 9/26/22 [8 days], there were only four CNAs. -There were 13 days with only five CNAs, 17 days with only six CNAs, and 8 days with only seven CNAs. -Only 11 days were covered by eight or more CNAs, most of those days in August. -Only 2 days in September (9/28 and 9/30) had 8 CNAs on the schedule. *The nurse and certified medication aide (CMA) numbers on the board showed 3 and 2 respectively, each day, while the August and September 2022 schedules revealed shortages: -For nurses, three days in August and four days in September. There was only one nurse on 9/17/22. -For CMAs, seven days in August and four days in September. 10. Interview on 10/04/22 at 1:25 p.m. with administrator (ADM) A and regional nurse consultant X regarding staffing revealed: *They have trialed several changes in staffing from eight hour shifts to twelve hours shifts. The change to twelve hours started the end of July. *Residents have been interviewed about staffing concerns. *Staff have been interviewed to see where they felt the high acuity cares were in the building. *ADM A acknowledged that she had not had a chance to update the Facility Assessment to reflect current acuities. *Staff need to use the "walkies [radios]" to communicate with each other. *Staff have not been willing to cross-over to help each other and will only work on their assigned hallway. "We are trying to change the culture." *Bath assignments were trialed two ways: -Had the CNAs give the baths assigned on their	F 725		

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	435039	A. BUILDING _____ B. WING _____	C 10/04/2022

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F 725	Continued From page 97 hallways each day instead of having an assigned bath aid. -After conducting a bath "Ad Hoc" quality improvement audit and discovered that baths did not get done that way, we now assign a bath aide every day to give all the baths. *We are "working to hold some nurses accountable to make correct decisions about reassigning staff." *We are making progress moving away from having contract staff; "we were at 80% [percent] contract staff and now it is 50/50 [50% contract to 50% hired}." 11. Refer also to F600, F677, F685, F686, F689, F692, and F809 for findings that demonstrate the impact that insufficient staffing had on unmet resident needs.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755	1. No immediate correction could be made for the missing nurses signatures on the narcotic count sheet. All narcotics are accounted for. The clear lock box in the refrigerator has been affixed to the refrigerator to prevent it from easily being removed. 2. All residents who take controlled medications are at risk for their medication being diverted. All narcotic medication has been accounted for. 3. The DON or Designee will educate all nurses on ensuring controlled substances are counted by two nurses at shift change. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked.	11/2/22

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F 755	Continued From page 98 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, Narcotic and Hypnotic Inventory Sheets review, and policy review, the provider failed to ensure accountability for all controlled substances for two of two observed medication carts and one of one medication refrigerator. Findings include: 1. Observation and interview on 9/29/22 at 7:50 a.m. with certified medication aide (CMA) DD of the East medication cart revealed: *Two nurses count controlled substances at shift change and she has to stay until the count is completed and accurate. *Both nurses are to sign off on the inventory sheets. *Agreed the inventory sheets did not have a signature present for all shift changes. Observation and interview on 9/29/22 at 8:10 a.m. CMA T of the Warren medication cart revealed: *Two nurses count controlled substances at shift change.	F 755	4. The DON or designee will review the controlled substance inventory sheets three times each week to ensure the count in signed off as complete and will check the refrigerator to ensure the lock box containing controlled substances is affixed to the fridge and unopened. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 755	Continued From page 99 *Both nurses are to sign off on the inventory sheets. *Agreed the inventory sheets did not have a signature present for all shift changes. Observation and interview on 9/29/22 at 12:18 p.m. with registered nurse (RN) Z regarding : *Two nurses do count controlled substances at shift change. *Both are to sign off on the inventory sheet. *Agreed that there were missing signatures on the inventory sheets for the East and Warren medication carts. Review of the East medication cart Narcotic and Hypnotic Inventory Sheets from 6/21/22 through 9/28/22 revealed 52 out of 382 missing signatures. Review of the Warren medication care Narcotic and Hypnotic Inventory Sheets from 7/5/22 through 9/28/22 revealed 21 out of 340 missing signatures. Interview on 9/29/22 at 1:45 p.m. with director of nursing (DON) B and regional nurse consultant (RNC) X revealed: *Two nurses where to count all controlled substances at shift change. *Both were to sign off on the inventory sheet. *Had not been aware this was not always done. 2. Observation and interview on 10/4/22 at 9:57 a.m. with RN Z of the Central nurse's station medication room revealed: *Only the nurses had a key to the room. *A clear plastic lock box in the refrigerator with a 30 millimeter (ml) bottle of lorazepam 2 milligrams (mg)/ml.	F 755		

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F 755	Continued From page 100 -The box had a keyed lock, but was not affixed to the refrigerator. *She did not know how or when the bottle of lorazepam was accounted for. *She did agree that someone could have taken the whole lock box. Interview on 10/4/22 at 10:05 a.m. with licensed practical nurse L regarding the above mentioned bottle of lorazepam revealed: *It was not counted at shift change. *It had been part of their emergency kit, if the needed to use it for a resident, it would have been removed from the lock box, an inventory sheet would be started, and nurses would then count it at shift change. *Only nurses had a key to the central medication room and the lock box inside the refrigerator. *Had agreed someone could take the whole lock box. Interview on 10/4/22 at 10:10 a.m. with DON B revealed: *The nurses did not count the bottle of lorazepam in the lock box at shift change. *Had agreed someone could take the whole lock box. 3. Review of the provider's November 2017 Controlled Substances policy revealed: "at each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on the audit record."	F 755		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals	F 809	1. Residents 9, 20, 25, 34, 36, 46, 50, 52, 63 and 73 are receiving fresh water and offered a snack at bedtime.	11/2/22

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F 809	Continued From page 101 §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure snacks and fresh water or other beverages were offered and available to 11 of 11 residents (9, 16, 20, 25, 34, 36, 46, 50, 52, 63, and 73). Findings include: 1. Observations on 9/27/22 at 9:59 a.m.,9/28/22 at 4:26 p.m., and 9/30/22 at 10:10 a.m. revealed resident 16: *Had a water mug with a straw on the overbed table positioned in front of her. *Her lips were pale in color, dry and chapped, and had flakes of skin on 9/27/22. *Her teeth appeared dull with yellow build-up and dry. *Moved her arms about in uncontrollable jerking movements. *Spoke with a muffled sound and moved her lips	F 809	2. All residents with at risk for not having fresh water or snacks. Water is passed at three times a day and upon request. Snacks are available throughout the day on each nursing units and offered to residents at bedtime. 3. The DON or Designee will educate all nursing staff on the following: Fresh water should be passed three times daily. Snacks are available on each nursing unit throughout the day and bedtime snacks must be offered to each resident and their acceptance marked as accepted or refused in point of care. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The DON or designee will interview five random residents each week to ensure resident received fresh water and was offered a snack at bedtime. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 809	Continued From page 102 only slightly. Review of resident 16's electronic health record revealed she had signs and symptoms of poor fluid intake. (Refer to F692, finding 1.) 2. Interview on 9/28/22 at 3:51 p.m. with CNAs S and V revealed: *CNA V had been working here for a few weeks, but CNA S started just on Monday, 9/26/22; both were already CNAs when they started. *The CNAs "have to pick up the water cups from each room and return with fresh water during the shift." *CNA V reported there was no system for doing that when she first started so she started putting tape on the mugs so she could tell when fresh water was last delivered to each room. *Snack carts had to be done by CNAs if it was going to be done. *They had not had time yet to pass fresh water or snacks. Interview on 9/30/22 at 10:12 a.m. with CNA S revealed She and the other CNA assigned to the wing had "not passed fresh water yet." 3. Interview on 9/29/22 at 10:00 a.m. with 7 residents (9, 34, 36, 50, 52, 63, and 73) interviewed during the resident group meeting agreed: *They got fresh ice water when they "ask for it," but it is not routinely distributed. *They had not seen a snack cart and had never been offered snacks at bedtime. 4. Interview on 9/27/22 at 4:02 p.m. with resident 20 revealed:	F 809		

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F 809	Continued From page 103 *She only got fresh water when she asked for it. *CNAs used to pass snacks but do not anymore. *One evening she had requested toast and peanut butter and was told that the kitchen was closed. -The next morning, she was served toast and peanut butter for breakfast. 5. Interview on 9/28/22 at 10:00 a.m. with resident 25 revealed: *There are no snacks passed during the day. *She does not request a snack every day. *Has been told by staff that there were no snacks available. 6. Interview on 9/27/22 at 10:30 a.m. with resident 46 revealed: *Fresh water was not offered. He had to ask staff or go get it himself. *Sometimes he is offered a snack and sometimes he must ask. 7. Interview on 9/28/22 at 3:54 p.m. with CNA AA regarding snack passes to the resident residing on the East wing revealed: *Snacks are supposed to be offered at 2:30 p.m. and bedtime. *Snacks were brought to the central nurse's station but not to the east wing. *If a resident wants a snack a staff person had to go to the central nurse's station to get it. 8. Interview on 9/28/22 at 4:09 p.m. with licensed practical nurse (LPN) BB regarding snack and water passes for the residents on the East wing revealed: *Fresh water should be passed every day at 2:00 p.m. and 7:30 p.m. or as needed. *Agreed the water did not get passed on the day	F 809		

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F 809	Continued From page 104 of the interview. *Snacks get passed in the afternoon. She had passed snacks out to the ones who wanted one. *Snacks are delivered to the central nurse's station and staff need to go there to get them. 9. Interview on 10/3/22 at 4:00 p.m. with director of nursing B regarding snack passes revealed: *The dietary staff brought a snack tray around in the afternoon and if needed again in the evening. *She was not aware a snack tray was not being delivered to the East wing. 10. Review of the provider's 4/30/18 Snacks policy revealed: *"Daily snacks are provided in accordance with the prescribed diet and in accordance with State law and according to residents' preferences and requests. Individual and/or bulk snacks are available at the nurses' station or other designated locations for consumption by residents. *1. At least one (1) snack is offered at bedtime daily. Snacks should also be available throughout the day per residents' preferences and requests. *2. A minimum of two (2) of the following four food components is offered to all residents for the bedtime snack: -a. Fruit or fruit juice. -b. Whole grain or enriched variety crackers. -c. Variety of cookies. *3. Bedtime snacks for calorie level diabetic and strict renal diets should be outlined on the menu. Diabetics on insulin should also receive a labeled bedtime snack. These snacks should be covered and: -a. Labeled with resident's name, room number and date. -b. Delivered to each nursing unit by Dietary.	F 809		

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F 809	Continued From page 105 -c. Offered to the residents by Nursing. -d. Delivered on ice or placed in the Nursing unit refrigerators immediately if desirable temperature is 41 F [41 degrees Fahrenheit] or less. *4. A snack menu should be given to Nursing so they will know what bulk snacks are appropriate for sodium, fat and calorie restricted diets, and modified consistency diets. *5. Acceptance or refusal of these snacks are noted on the Activities of Daily Living (ADLs) where possible. *6. Snacks preferred by residents are a good way to add calories and protein to their diet."	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy	F 812	1. The following areas in the kitchen were cleaned: the oven and deep fat fryer were cleaned of the oil and dried food; the shelving unit was cleaned and is free from crumbs; the oily film on the range hood and vents was cleaned; and the wall mounted fan was cleaned. 2. All residents with at risk from food borne illness from food prepared in an unsanitary kitchen. Cleaning schedules have been implemented and the kitchen is being cleaned routinely. 3. The Administrator or Designee will educate all dietary staff on the newly implemented cleaning schedules. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The Administrator or designee will conduct a kitchen walk through three times a week at varying times to ensure the kitchen is clean. The cleaning checklists will be reviewed to ensure they are signed off as complete.	11/2/22

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F 812	Continued From page 106 review the provider failed to ensure proper sanitation practices for: *One of one oven had a large amount of dried on food and grease running down the side. *Deep fat fryer had grease stains running down the side. *Shelving unit next to the oven covered in crumbs. *Range hood and vents covered in an oily film. *Wall mount fan had lint and dust built up on the back side. 1. Observation on 9/27/22 between 9:01 a.m. and 10:42 a.m. in the main kitchen revealed: *The oven had a large amount of dried on food and grease running down the side of it. *The deep fat fryer had: -grease stains running down the side of it. -A small food strainer hanging next to it. --There was a baseball sized puddle of grease below the strainer on the floor. *The gas line behind the deep fat fryer had dried grease formed on it on both sides of the fryer. *The shelving unit next to the oven had: -A layer of crumbs built up on it. -A pan on the bottom shelf that had an oily film with a layer of crumbs stuck to it. *The range hood above the oven had a thick layer of oil on the edges and vents that had formed droplets. -Documentation on the range hood revealed it had been cleaned by Superior Hood Steamers in May of 2022. *There was an oscillating fan mounted on the wall that: *Had lint and dust built up on the backside and on the pull chains. *Was blowing air across the food preparation table and the stove.	F 812	Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 812	Continued From page 107 Interview on 9/29/22 at 9:00 a.m. with dietary manager F regarding the cleanliness of the kitchen revealed he: *Agreed the kitchen needed a deep cleaning. *Did not have documentation for daily, weekly and monthly cleaning schedules. *Needed to get cleaning schedules in place. Review of the providers 8/31/2018 revised cleaning schedules policy revealed: *"The Food and Nutrition Services staff shall maintain the sanitation of the Food and Nutrition Services Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinically qualified nutritional professional. Procedure 1. The Director of Food and Nutrition Services or other qualified nutrition professional shall record all cleaning and sanitation tasks for the Food and Nutrition Department. 2. A cleaning schedule shall be posted with tasks designated to specific positions in the department. 3. All tasks shall be addressed as to frequency of cleaning."	F 812		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at	F 838	1. The facility assessment was updated by the Administrator, DON and IDT in collaboration with the medical director and governing board and input from direct care staff, residents, and family. The following policies were reviewed relevant to the processes and system failures identified in the deficient practices: Homelike Environment Policy (F584); Abuse and Neglect Policy (F600); Care Plans (F656);	11/2/22

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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 838	Continued From page 108 least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies	F 838	Following Physician Orders Policy and Weight the Resident Policy (F658); Bathing Policy (F677); Catheter Care, Pain Management and Dietary Preferences (F684); Skin Program Policy (F686); Falls Management Policy (F689); Controlled Substances Policy (F755); Bedtime Snacks (F809); Kitchen Sanitation (F812); Antibiotic Stewardship Program (F881). A new policy was created and approved for F574, Required Notices and Contact Information. 2. All residents are at risk for not getting the required care based on lack of comprehensive review of the current resident population and staffing requirements. The facility assessment has been updated. 3. The Regional Director of Operations will educate the Administrator on the facility assessment requirements no later than October 28, 2022. 4. The Regional Director of Operations will review the facility assessment quarterly and report any findings to the monthly QAPI meeting with the IDT and Medical Director for any analysis and recommendations.	

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	435039	A. BUILDING _____ B. WING _____	C 10/04/2022

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F 838	Continued From page 109 related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and facility assessment review, the provider failed to ensure a facility-wide assessment had been updated annually to include a comprehensive review of the current resident population and staffing requirements. Findings include: 1. Review of the Facility Assessment revealed it was dated 5/24/21 and was based on an average daily census of 52 residents. *The facility census on the 9/27/22 Resident List Report listed 79 residents total. *Comparative Review of the staffing numbers posted on the dry erase board in the conference room and the August and September 2022 nursing schedules revealed (Refer also to F725, findings 9 and 10): *The CNA numbers on the board listed eight CNAs, without specifying which shift. *The August and September 2022 schedules revealed: -Only 11 days were covered by eight or more	F 838		

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F 838	Continued From page 110 CNAs, most of those days in August. -Only 2 days in September (9/28 and 9/30) had 8 CNAs on the schedule. *The nurse and certified medication aide (CMA) numbers on the board showed 3 and 2 respectively, each day, while the August and September 2022 schedules revealed shortages: -For nurses, three days in August and four days in September. There was only one nurse on 9/17/22. -For CMAs, seven days in August and four days in September. Interview on 10/04/22 at 1:25 p.m. with administrator (ADM) A and regional nurse consultant X regarding staffing revealed she acknowledged that she had not had a chance to update the Facility Assessment to reflect current acuities.	F 838		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880	1. For the identification of lack of: *Appropriate hand hygiene and glove and all personal protective equipment uses when completing dressing change of resident(s) with more than one area dressed. MRSA diagnosis.*Appropriate maintenance and cleaning of multi-resident use equipment between residents. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by November 2, 2022 by DON or Designee	11/2/22

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 111 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	**2. Identification of Others:** ALL residents and staff have the potential to be affected by lack of: *Appropriate hand hygiene and glove and all personal protective equipment use when completing dressing change of resident(s) with more than one area dressed. *Appropriate maintenance and cleaning of medical equipment between residents. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by November 2, 2022 by DON or Designee. **System Changes:** 3. The cited deficiency was reviewed. Root cause analysis conducted answered the 5 Whys: *Lack of monitoring of disinfecting of universal equipment *Lack of training -wound care, hand hygiene, PPE Donning/Doffing, and multiple dressing changes on multiple wounds. *Lack of competencies completed- wound care, hand hygiene, PPE donning/doffing *Lack of monitoring/auditing of wound care. *Utilization of agency staff and frequent staff changeovers. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. **Administrator, DON, and RNC** contacted the South Dakota Quality Improvement Organization (QIN) on **10/20/2022** and Reviewed 2567 F880 and examples cited dressing change issues, cleaning processes of vital sign machine between resident use.	

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F 880	Continued From page 112 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices had been maintained for: *One of one observed dressing change by one of one licensed practical nurse (LPN) (BB) for a resident who was on contact precautions related to methicillin-resistant Staphylococcus aureus (MRSA). *One of one observed LPN (CC) using a portable vital signs machine without disinfecting it between use for three of three residents (12, 14, and 25). Findings include: 1. Observation on 9/28/22 at 9:40 a.m. of LPN BB changing resident 25's dressing to bilateral lower legs and heels in resident 25's room revealed: *Resident 25 was sitting in her wheelchair with her legs elevated on a pillow and the foot pedals. There was a disposable chux between her legs and the pillow. *With a pair of gloves, gown, face mask, and eye protection on she: -Gathered dressing supplies, set some of them on the uncleaned bedside table and some of them on the bed, without a barrier under them. -Pulled out a tube of Medihoney from her pants pocket.	F 880	Facility has started education and mitigation actions (audits, reeducation, policy review, competency checks). Reviewed QIO website and resources. Reviewed 5 why's in the root cause analysis. **Monitoring:** 4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 113 -Removed dressings to bilateral lower legs. *Changed her gloves without performing hand hygiene and she: -Ripped open a few packages of 4 x 4 gauze pads, removed the pads, and set them back on top of the empty packages, on the uncleaned bedside table. -Poked a hole in the top of a container of normal saline, poured it over the wounds to bilateral lower legs, and cleaned the wounds with the 4 x 4 gauze pads. -Removed a dressing from her right heel and applied a new one. *Changed her gloves without performing hand hygiene and she: -Applied a dressing to the left heel. -Applied petroleum gauze to the wound on the right lower leg and coved it with two abdominal (ABD) pads. -Set two ABD pads on the soiled disposable chux under resident 25's legs and then put them back on the bed. -Applied petroleum gauze to the wound on the left lower legs and covered it with the two ABD pads from the bed. -Picked up a roll of tape and ripped off two pieces and had resident 25 hold them while she wrapped the first lower leg with gauze and used the tape to hold in place. --Repeated this step to the second leg. -Asked resident 25 if she had hand sanitizer. Resident 25 reached behind the wheelchair and dug through a drawer touching other items in the drawer to find the sanitizer and used it to perform hand hygiene for herself. -Removed the soiled chux and put it in the garbage. *Removed her gloves. *Put a new disposable chux under resident 25's	F 880		

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F 880	Continued From page 114 legs and assisted her to put on heel protectors. *Put the supplies away in the room. *Moved the bedside table. *Reached out into the hall, retrieved a container of disinfecting wipes. *Used the wipes to clean the scissors, table, and a marker. *Set the wipes back in the hallway. *Removed her gown and exited the room. *Did not change her mask or clean her eye protection. Interview on 9/28/22 at 10:30 a.m. with LPN BB regarding the above observation with resident 25 revealed she: *Knew resident 25 had MRSA. She did not know if the MRSA was in one wound or all wounds. *Thought she could change her gloves three or four times before she had to perform hand hygiene. *Did not know she should have used a barrier under the clean dressing supplies. *Agreed moving the supplies from the soiled chux to the bed could have contaminated the bed. *Was going to change her face mask but had to go to the nurse's station to get one as there were none available in the personal protective equipment (PPE) supply cart outside the room. *Agreed having the resident help with the dressing change and digging into her drawer for the hand sanitizer could have contaminated the items in the drawer. *Was not aware she should have changed the dressings to one wound at a time to prevent cross contamination of those wounds. *Had not had anyone complete a dressing change competency with her. Interview 9/29/22 at 2:00 p.m. with director of	F 880		

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F 880	Continued From page 115 nursing (DON) B and regional nurse consultant X revealed: *LPN BB should have performed hand hygiene with each glove change and when removing her gloves. *A barrier should be used under clean dressings. *Moving the dressings from the contaminated area to the bed could have contaminated the bed. *The resident should not have assisted with the dressing change. *LPN BB should have performed dressing changes to one wound at a time. Review of LPN BB's infection control education provided by the provider revealed on: *11/4/21 she had COVID-19 education which included hand hygiene, PPE, and barriers. *6/23/22 she had acknowledged she had received educational handouts and had no questions regarding: -"Break the Chain of Infection (2016 APIC)." -"Infection Prevention and You in Long-Term Care (APIC)" -Do's and Don'ts for Wearing Gloves in the Healthcare Environment (APIC)." Review of the provider's May 2021 Standard Precautions policy revealed: *"PPE will be available in cart outside transmission-based precaution room (Contact, Droplet, or Enhanced Droplet - combination of Contact and Droplet)." *"Hand hygiene should be performed prior to application and after removal of gloves." *"Gloves should be removed, hand hygiene performed and a new pair of gloves applied before moving from a contaminated area to a clean area."	F 880		

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F 880	Continued From page 116 A dressing change policy had been requested from administrator A on 9/29/22 at 1:30 p.m. an undated Dressing Change Competency - Aseptic Technique form was provided, and it revealed: *A barrier was to be used under clean dressing supplies. *Gloves should be changed, and hand hygiene performed after removing a soiled dressing, after cleaning a wound, and after applying a new dressing. *It did not address how to complete dressing changes for a resident with multiple wounds. 2. Observation on 9/29/22 at 7:53 a.m. of LPN CC pushing a portable vital signs machine down the east wing revealed she: *She went into residents 12, 14, and 29's rooms and used the machine to obtain their vitals. *Had not disinfected the machine between use. Observation and interview on 9/29/22 at 10:43 a.m. with LPN CC regarding the above observation revealed she: *Was sitting at the East wing nurses' station and there was a container of disinfecting wipes on the desk next to her. *Knew she should have disinfected the portable vital signs machine between use. *Did not know where the disinfecting wipes were located. Interview on 10/3/22 at 3:41 p.m. with DON B regarding disinfecting the portable vital signs machine revealed she: *Expected all staff to disinfect all re-usable medical equipment between use on residents. *They had a supply of disinfecting wipes. Review of the provider's 4/10/20 Cleaning and	F 880		

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F 880	Continued From page 117 Disinfection - COVID-19 policy revealed: "Cleaning and disinfection will be completed after use of shared equipment."	F 880		
F 881 SS=F	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 interview, record review, and policy review, the provider failed to provide adequate oversight of antibiotic use in the facility by failing to ensure one of two antibiotic orders reviewed had been signed by a provider, two of two antibiotic orders reviewed had been assessed for antibiotic time-out (ATO), and two of two antibiotic orders reviewed met clinical criteria for antibiotic use. Findings include: 1. Review of resident 20's medical record revealed: *On 9/19/22 she had been seen by a certified nurse practitioner (CNP) and an order was written for a urinalysis with reflux to culture. *There had been no documentation in the record to show she was having signs or symptoms of a urinary tract infection (UTI). *On 9/23/22 there had been an unsigned hand written order on the urine culture results to start Cefuroxime 250 milligrams twice a day for five	F 881	1. No immediate correction could be made for residents 20 and 61's administration of an antibiotic without applying McGeers criteria or conducting an antibiotic time out. 2. All residents with at risk from unnecessary antibiotic use. All antibiotic orders are reviewed by the DON each morning during morning start up. 3. The Administrator, DON and Infection Prevention nurse will be educated by the Regional Infection Preventionist on the requirements of the Antibiotic Stewardship Program. The DON or designee will educate all nurses on ensuring signs and systems of possible infection are documented in the medical record and to ensure any antibiotic orders received list the reason for use. The education will occur no later than November 2, 2022 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked. 4. The DON or designee will audit all antibiotic orders to ensure McGeer Criteria is used, antibiotic time out is conducted, documentation of signs and symptoms are included in the medical record and antibiotic order includes an indication for use. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	11/2/22

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F 881	Continued From page 118 days. Interview on 10/3/22 at 3:55 p.m. with director of nursing B regarding resident 20 revealed: *Nurses should have documented in the medical record if resident 20 was having signs or symptoms of an UTI. *The provider did not use any form of clinical criteria (such as McGeers) prior to starting an antibiotic. *They gave antibiotics based on what the physician ordered. *She had agreed the CNP had not signed the order for Cefuroxime and the nurse should have called to clarify and documented the conversation in resident 20's medical record. *Did not do an ATO. 2. Interview on 10/3/22 from 4:40 p.m. to 5:10 p.m. with DON B and regional nurse consultant (RNC) X about the provider's antibiotic stewardship program revealed: *DON B ran a monthly report on all the different antibiotics that were used in the facility. *She would review the orders for accuracy. *She had a map of the facility that she used to track which residents had an infection, what type of infection, and what antibiotic was being used. -The map was used to track infection trends and to find the source of the infections. *She was not investigating any infections at that time. *They used McGeer criteria for infection surveillance user-defined assessment (UDA) when a resident was placed on an antibiotic. *RNC X mentioned she saw a trend of their providers prescribing an antibiotic for only three	F 881		

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F 881	Continued From page 119 days. -They did not have a system in place to monitor for antibiotic time-out other than relying on the providers prescribing an antibiotic for only three days. *Only one resident (61) was receiving an antibiotic at the time of the interview. *DON B and RNC X reviewed resident 61's electronic medical record and confirmed: -On 9/29/22, Resident 61's provider ordered "azithromycin tablet 250 mg: Give 500 mg by mouth one time a day for infection for 1 Day THEN Give 250 mg by mouth one time a day for infection for 4 Days." -No one had assessed for antibiotic time-out. -No one had completed the McGeer criteria for infection surveillance UDA for resident 61, when it should have been completed. -They could not find in the progress notes or scanned documents why resident 61 had been prescribed antibiotics, when there should have been evidence in resident 61's electronic medical record as to why the antibiotic was started. Review of resident 61's electronic medical record revealed: *On 9/29/22, an order was started for "azithromycin tablet 250 mg: Give 500 mg by mouth one time a day for infection for 1 Day THEN Give 250 mg by mouth one time a day for infection for 4 Days." *A McGeer criteria for infection surveillance UDA was not initiated. *A health status note dated 9/28/22 at 12:25 p.m. read, "Data: orders received 9/28/22 after [primary care provider] rounds; [provider's name] orders; 1) azithromycin (zpack) 500mg [by mouth] day 1, then 250mg daily x 4 days..." -There were no notes as to why the antibiotic was	F 881		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435039	A. BUILDING _____ B. WING _____	C 10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(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 881	Continued From page 120 started. Review of provider's antibiotic stewardship program policy revealed: *Page three, under the "Accountability" section: -"vi. Utilize an antibiotic review process, also known as 'antibiotic time-out' (ATO) for all antibiotics prescribed in the facility. ATOs prompt clinicians to reassess the ongoing need for a choice of an antibiotic when the clinical picture is clearer and more information is available. --1. At 48-72 hours after antibiotic initiation or first dose in the facility, each resident will be reassessed for consideration of antibiotic need, duration, selection, and de-escalation potential (e.g. reducing dose or using narrower spectrum antibiotic instead of broad spectrum). At this time, laboratory testing results, response to therapy, resident condition, and facility needs (e.g., outbreak situation) will be considered. This evaluation must be documented on the Antibiotic Time Out Review Progress Note." *Page three, under the "Tracking" section: -"a. [Infection preventionist] will be responsible for infection surveillance and [multi-drug resistant organism] tracking. -b. [Infection preventionist] should collect and review data/measurements such as: --i. Antibiotic prescriptions orders for completeness: dose, route, frequency, duration, and indication. --ii. Whether appropriate tests such as cultures were obtained before ordering antibiotic."	F 881		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 from 9/27/22 through 9/30/22, and on 10/3/22 through 10/4/22. Avantara Norton was found in compliance.	E 000		

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

Ashley Nickel | LNHA | 10/22/2022

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

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	435039	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	**3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105**

(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 for compliance with the Life Safety Code (LSC) (2012 existing healthcare occupancy) was conducted on 9/28/22. Avantara Norton was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing healthcare occupancies upon correction of deficiencies identified at K223, K293, K321, K353, K712, and K914 in conjunction with the provider's commitment to continued compliance with the fire safety standard	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain three sets of doors installed to create smoke zones (west wing, center wing, and	K 223	1. Cross Corridor doors separating west wing from center wing has been repaired. Cross Corridor doors separating center from east wing have been repaired. Cross Corridor doors separating the zones at the beauty salon were repaired. 2. All residents are at risk for safety. 3. Educate Maintenance Director by 11/2/22 regarding the importance of Doors with Self-Closing Devices by Administrator or Designee. 4. Administrator or Designee will complete initial audit of all doors for proper function and closure. Administrator or Designee will Audit 5 random doors weekly x 4 weeks and monthly x3 months.	11/2/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nickel	LNHA	10/22/22

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

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	435039	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2022**

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K 223	Continued From page 1 east wing) as required. Findings include: 1. Observation on 9/28/22 at 9:45 a.m. revealed the cross-corridor doors separating the west wing from the center wing were held open with a magnet tied into the fire alarm system. The doors were 60 minute doors, but did not latch when released from the magnet. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for smoke zone separation and had the potential to affect 100% of the occupants of those smoke compartments. 2. Observation on 9/28/22 at 9:45 a.m. revealed the cross-corridor doors separating the center wing from the east wing were held open with a magnet tied into the fire alarm system. The doors did not close when released from the magnet because a tile obstructed closure. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for smoke zone separation and had the potential to affect 100% of the occupants of those smoke compartments. 3. Observation on 9/28/22 at 2:45 p.m. revealed the cross-corridor doors separating the zones at the beauty salon were held open with a magnet tied into the fire alarm system. The doors did not close when released from the magnet because the tile obstructed closure.	K 223		

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K 223	Continued From page 2 Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for smoke zone separation and had the potential to affect 100% of the occupants of those smoke compartments.	K 223		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain exit signs for one of one exit location in the kitchen. Findings include: 1. Observation on 9/28/22 at 1:30 p.m. revealed one exit sign was in the kitchen to exit outside. The exit signage was hanging down from the power cord into the exit door space revealing the broken back of the sign. Interview with the maintenance director at the times of the observations confirmed the finding. The deficiency affected the kitchen staff's direct access to the outside with a marked and identifiable path of egress.	K 293	1. Exit sign in the kitchen has been replaced and secured properly. 2. All residents are at risk 3. Educate Maintenance Director by 11/2/22, regarding importance of exit signs by administrator or designee. 4. Administrator or designee will audit 5 random exit signs weekly x4 weeks and monthly x3 months.	11/2/22
K 321	Hazardous Areas - Enclosure	K 321		

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K 321 SS=F	Continued From page 3 CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain four separate hazardous areas (wing previously used as memory care, utility room, soiled laundry storage, and center basement generator room) as required. Findings include:	K 321	1. Combustible items will be removed from memory care, and placed behind appropriately rated doors by 11/2/22. All storage will be removed from memory care by 11/2/22 and stored in appropriate space. Utility room will have 1 inch holes repaired and 2 inch carrier pipes filled with fire sealant by 11/2/22. Laundry door has been repaired. Concrete block in generator room will have been sealed by 11/2/22. 2. All residents are at risk to be affected. 3. All staff education will be provided on appropriate storage in the facility by 11/2/22 by Administrator or Designee. Education will be provided to Maintenance Director on appropriate storage, and Fire prevention requirements in the facility by Administrator or designee by 11/2/22. 4. Audits will be completed by Administrator or Designee for appropriate storage of combustibles, and storage items weekly x4 weeks and monthly x 3 months. Audits of high risk Hazardous areas will be audited weekly x4 weeks and monthly x3 months.	11/2/22

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K 321	Continued From page 4 1. Observation on 9/28/22 at 10:15 a.m. revealed the wing previously used as memory care was over 100 square feet, contained combustible items and did not have appropriately rated doors. - The entire space, rooms as well as corridors, were used as storage. The storage space was over 1500 square feet. - The storage space would be required to meet new hazardous space requirements, not existing requirements as the existing space was constructed for resident space. 2. Observation on 9/28/22 at 10:25 a.m. revealed utility room used for information technology (IT) on the "Warren" unit was over 100 square feet, contained stored combustible items and did not have appropriately sealed partitions. - There were two 1-inch holes in the exterior wall which were not filled with fire sealant. - There were four 2-inch carrier pipes for IT cabling which were not filled with fire sealant. 3. Observation on 9/28/22 at 11:20 a.m. revealed the soiled laundry storage within the laundry room was not protected by a latching door. 4. Observation on 9/28/22 at 1:45 p.m. revealed the center basement fuel-fired generator room did not have appropriately sealed partitions. The concrete block walls had three unsealed penetrations: 2-inch diameter hole, 4-inch by 5-inch hole, and 6-inch diameter hole. Interview with the maintenance director at the times of the observations confirmed those findings. The deficiencies affected three of numerous	K 321		

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K 321	Continued From page 5 requirements for hazardous rooms.	K 321		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly valve testing not done). Findings include: 1. Record review on 9/28/22 at 3:30 p.m. revealed the required quarterly tests had not been performed in the past year. Annual tests were performed by contract on the dry sprinkler system, but no valve testing had been performed. Interview with the maintenance supervisor at the time of the record review confirmed that	K 353	1. New Maintenance Director hired. Initiating new contract with Sprinkler System Company. Will be scheduled quarterly. 2. All residents are at risk to be affected. 3. Administrator or Designee will educate Maintenance Director regarding quarterly Sprinkler System Checks. 4. Administrator or Designee will audit completion of Sprinkler system checks quarterly for 6 months.	11/2/22

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K 353	Continued From page 6 condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic sprinkler system.	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review, the provider failed to ensure staff were familiar with the provider's fire drill procedures (frequency of drills). Findings include: 1. Record review on 9/28/22 at 2:15 p.m. revealed only one fire drill was documented during the second shift in the past twelve months. Overall, only one fire drill was performed during the first quarter of 2022, and two of the three were performed during the second quarter of 2022.	K 712	1. New Maintenance Director Hired. All fire drills are on an rotating shift schedule. Fire drills will be completed on a different shift each month to meet quarterly requirements. 2. All residents are at risk to be affected. 3. Administrator or Designee will educate maintenance director regarding rotation of shifts with fire drills. 4. Administrator or Designee will Audit Fire Drills monthly x 6 months for rotating shifts.	11/2/22

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K 712	Continued From page 7 An interview with the maintenance supervisor at the time of the observation confirmed those findings. He had only been hired five weeks previously and maintenance staffing had been sporadic. The deficiency had the potential to affect 100% of the occupants of the building.	K 712		
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document the generator battery conductivity at a monthly interval (no	K 914	1. New Maintenance Director Hired. Battery conductivity for facility generators will be completed monthly by Maintenance Director or designee. 2. All residents are at risk to be affected. 3. Administrator or designee will educate Maintenance Director on importance of Generator Maintenance and testing of battery. 4. Administrator or Designee will complete audits of monthly generator testing monthly x 6 months.	11/2/22

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K 914	Continued From page 8 documentation for 2021 or 2022). Findings include: 1. Record review on 9/28/22 at 2:45 p.m. revealed there was not any documentation of the battery conductivity in the monthly maintenance logs for the generator for the calendar year 2021 and 2022. Interview with the maintenance supervisor on 9/28/22 at 3:15 p.m. revealed the generator had a maintenance-free battery installed and it could not be tested for specific gravity. He stated he was unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants.	K 914		

South Dakota Department of Health

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	10682	A. BUILDING: _____ B. WING _____	10/04/2022

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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 9/27/22 through 9/30/22, and on 10/3/22 through 10/4/22. Avantara Norton was found not in compliance with the following requirements: S236 and S301.	S 000		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;	S 236	1. Staff member F is no longer employed at the facility. 2. All residents are at risk of exposure from a staff member who does not receive a TB screening test. All staff members have been appropriately screened for TB. 3. The Administrator, DON, Infection Preventionist have will be educated no later than November 2, 2022 on the South Dakota Administrative Rule on TB skin testing. 4. The Administrator or designee will review all newly hired personnel to ensure TB skin testing is complete within 14 days of hire. Audits will be weekly for four weeks, and then monthly for three months. Results of audits will be discussed by the Administrator at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings	11/2/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Nickel — TITLE: LNHA — (X6) DATE: 10/22/22

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AVANTARA NORTON	3900 S NORTON AVENUE SIOUX FALLS, SD 57105

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S 236	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel file review and interview, the provider failed to ensure one of five sampled employees (F) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of dietary manager F's personnel file revealed he was hired on 3/7/22 and there was no documentation of any TB skin test. Interview on 10/3/22 at 2:45 p.m. with human resources director H revealed dietary manager F was going to bring in TB skin test documentation from his military medical file but had not done so. Review of the provider's November 2019 Tuberculin Skin Test (TST) Administration and Interpretation policy revealed: *"The facility will administer and interpret TSTs in accordance with guidelines." *It had not specified a timeline of when the TST was to be administered or completed.	S 236		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.	S 301	1. Staff member F is no longer employed at the facility. Staff member Y has received the required training. 2. All residents are for unsafe dietary practices when staff are not educated on dietary and food handling requirements. All dietary staff and those who handle food in the course of their duties will be educated all on required dietary practices no later than November 2, 2022. Those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return prior to their first shift worked.	11/2/22

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10682	A. BUILDING: _____ B. WING _____	10/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3900 S NORTON AVENUE SIOUX FALLS, SD 57105

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S 301	Continued From page 2 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure all required dietary training (food safety, food handling/preparation, food borne illness, leftovers, time/temperature controls, nutrition/hydration, and sanitation) were completed by dietary manager F and cook Y. Findings include: 1. Review of dietary manager F's education record revealed: *He was hired on 3/7/22. *He had completed hand washing and serving/distribution training during his initial orientation. Review of cook Y's education record revealed: *She was hired on 6/1/22. *She had completed hand washing and serving/distribution training during his initial orientation. Interview on 9/29/22 at 9:01 a.m. with dietary manager F revealed he: *Was unsure of the dietary training that needed to be done upon hire and annually. *Referred to the administrator to verify what training needed to be done. Interview on 9/29/22 at 10:41 a.m. with administrator A revealed: *It was her expectation dietary training would be done during initial orientation and annually. *She agreed it was not getting done like it should. Interview on 10/4/22 at 11:36 a.m. with registered dietitian consultant G confirmed: *She provided the dietary training for new staff orientation and annual training to the previous	S 301	3. The RD will educate the Administrator, DON , HR Director and Dietary Manager will be educated on South Dakota Administrative Rules for the required dietary in-services no later than November 2, 2022. 4. Administrator or designee will audit all new hires each week to ensure the required dietary in-services were provided at orientation. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be discussed by the Administrator at the monthly QAPI Meeting to identify trends or additional education needs and will include continuation or discontinuation of audits based on the findings.	11/2/22

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 301	Continued From page 3 administrator. *It is the providers responsibility to schedule the training when staff need it. A policy for dietary training was requested from administrator A on 9/29/22 at 10:41 a.m. but none was furnished by the end of the survey.	S 301		