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
	435086	A. BUILDING ______ B. WING ______	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

(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 A COVID focused infection control survey and an extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/09/21 through 11/11/21, and 11/15/21 through 11/18/21, with exit interview conducted on 11/22/21. Riverview Healthcare Center was found not in compliance with the following requirements: F550, F553, F561, F565, F572, F575, F578, F580, F585, F600, F625, F636, F656, F658, F660, F679, F684, F686, F689, F698, F740, F744, F756, F760, F761, F801, F804, F809, F812, F835, F837, F880, F885, and F886. On 11/9/21 at 2:40 p.m., immediate jeopardy was identified related to COVID infection control practices and testing at F880 and F886. On 11/10/21 at 1:40 p.m., executive director A, director of nursing services B, and divisional director of clinical operations C, provided a removal plan per email. The removal plan was accepted on 11/10/21 at 1:50 p.m. Immediacy was removed on 11/11/21 at 9:40 a.m. On 11/16/21 at 2:52 p.m., an immediate jeopardy was identified related to neglect at F600. On 11/17/21 at 12:37 p.m., the removal plan was accepted with agreed upon changes made by the provider. Immediacy was removed on 11/18/21 at 3:00 p.m. On 11/18/21 at 3:00 p.m. executive director A requested the team leave the building without completing all survey tasks and interviews. An offsite exit interview was conducted on 11/22/21 at 11:30 a.m. with ED A, director of nursing	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Timothy Yeaton*
TITLE: *Executive Director*
(X6) DATE: *1/4/2022*

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.

JAN 04 2021

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F 000	Continued From page 1 services B, and divisional director of clinical operations C. The resident census was 36.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550	1. All residents have the potential to be affected. Unable to correct deficient practice identified during survey for residents 4, 17 and 22. Resident 183 is discharged. 2. Executive Director or designee will educate all staff on ensuring dignity is maintained for all residents including LPN E. Education will be provided by 12/22/2021. All staff not in attendance will be educated prior to their next working shift. 3. Audits on ensuring dignity is maintained will be conducted weekly times four and monthly times two months by ED or designee. The ED or designee results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. Addendum: Resident #22 diagnosis of hypochondriac removed. TY 1/4/22	12/22/21

F 550 Continued From page 2 F 550

from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the provider failed to maintain dignity for four of four sampled residents (4, 17, 22, and 183). Findings include:

1. Observation on 11/9/21 at 11:00 a.m regarding resident 22 revealed:
*Her pants were soiled.
*She was walking with her walker down the hallway crying.
*Staff encouraging her to keep walking to her room.
*Staff did not drape anything around her or walk behind her to cover her soiled pants.

Record review of resident 22's care plan revealed:
*"I tend to be a Hypochondriac."
*"I often think I have chest pain."
*"I am taking antianxiety/antipsychotic/antidepressant medication for anxiety, depression and psychosis."
*Resident 22 did not have a diagnosis of Hypochondria.

2. Observation and interview on 11/15/21 at 8:42 a.m. with licensed practical nurse (LPN) E and resident 4 revealed:

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*LPN E was completing medication pass outside of resident 4's door.
*Resident 4 was asking for help locating her drink.
*LPN replied to resident 4 by stating, "It's right in front of you [resident 4's first name]."

Review of resident 4's electronic medical record revealed resident 4:
*Was legally blind.
*Had a Charles Bonnet syndrome, which causes a person to have hallucinations or see things that were not real.

3. Observations made throughout the survey of resident 183 revealed he had been lying in bed without a brief on. Refer to F600, finding 1.
4. Observation on 11/15/21 at 10:37 a.m. of resident 17 revealed:
*She was sitting on the edge of the bed in her room, leaning to her right side with her pants down around knees, exposing her incontinent brief and skin on her upper thighs.
*The privacy curtain was not pulled and the room door was open, which provided a clear view of the resident through the doorway from the hallway.

At 10:40 a.m., certified nursing assistant (CNA) O wheeled resident 17's roommate in her wheelchair into the room. CNA O turned her head to observe resident 17 but continued to assist her roommate. CNA O had no interaction or acknowledgement of resident 17 and left the room while resident 17 remained sitting on the edge of her bed with her slacks down around knees.

Review of resident 17's electronic medical record revealed:

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F 550	Continued From page 4 *On the 10/25/21 quarterly minimum data set (MDS) assessment, her cognitive status was scored as moderately impaired. *Her 11/15/21 care plan identified bladder incontinence, incontinent brief use, and the need for staff assistance with incontinence and clothing change. On 11/18/21 at 9:00 am., administrator A was requested to provide a copy of the provider's policy on dignity. Administrator A replied at 1:46 p.m. that there was no provider policy as dignity was a standard of practice. On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any	F 553	1. All residents have the potential to be affected. A care conference has been offered and refused for resident 4 and 29. 2. The ED or designee will educate the interdisciplinary team on proper scheduling and inclusion of residents in the care planning process prior to 12/22/21. Anyone not in attendance the ED or designee will educate prior to their next working shift. 3 The ED or designee will audit the proper scheduling and participation for care conferences weekly times four weeks and monthly times two months. The results of these audits will be taken to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	12/22/21

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F 553	Continued From page 5 other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and admission packet review, the provider did not ensure 2 of 13 residents (4 and 29) had the opportunity to participate in the development of their person-centered plans of care. Findings include: 1. Interview on 11/16/21 at 8:47 a.m. with resident 29 revealed she "did not know" there was a care plan meeting that she could have attended to talk about her care plan. Resident 29 also reported concerns regarding: *Restoring her ability for "getting up and going." *Needing to get her hair styled and her nails groomed. *Only getting a bath because she insisted on getting one.	F 553	Addendum: The IDT team was educated on providing invitation to the family/responsible party/resident two weeks prior to the care conference and accommodate their preference. TY/1/4/22.	

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*Being able to do her in-room activities of coloring and word puzzles.
*Having "fear about running out of oxygen."
*Not getting out of her room to interact with others because she thought someone asked here why she was wasting oxygen when the resident she was using an oxygen tank in the therapy room.
*Not wanting to leave her room for meals but being told she "had to go to the dining room."

Observation of resident 29 during the interview revealed she:
*Grimaced and held her stomach a few times while lying in bed, and explained her stomach was bothering her.
*Was using an oxygen concentrator.
*Had unkempt hair that was not brushed, frizzy, and standing up on end.
*Had long fingernails with dark colored residue under the tips of the nails.
*Had a basket of activity supplies, including coloring pages, next to the recliner in her room.

Review of the 10/21/21 admission minimum data set (MDS) assessment in the electronic medical record (EMR) for resident 29 revealed she:
*Entered the facility on 10/15/21.
*Had no difficulties with communication, vision, hearing, or cognitive function.
*Had trouble concentrating on several days and "inattention" that was present continuously over the two weeks prior to 10/21/21, which was different from her baseline mood and mental status.
*Said it was very important for her to choose and do her preferences for daily routine and activities.
*Needed physical help transferring between surfaces and moving about with her walker and wheelchair.

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F 553	See below	F 553		

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Review of resident 29's care plan in the EMR revealed the following focuses:
*On 10/21/21, oxygen therapy and multiple diagnoses-related focuses without interventions to address her fear and use of the oxygen concentrator versus portable oxygen tanks.
*On 10/28/21, little to no activity involvement due to anxiety without interventions related to in-room activity preferences nor supporting the use of oxygen when out of her room.
*No focuses to address her preferences for daily routines, including bathing and grooming.

Review of the progress notes in resident 29's record revealed no notes to document an effort to invite the resident and/or responsible party to the care plan meeting nor which focuses were reviewed and revised during the meeting.

Surveyor 42477:
2. Observation and interview on 8/15/21 at 8:10 a.m. with resident 4 revealed:
*Staff had just gotten her up and dressed for the day.
*The tone of her voice indicated she was not very happy and had not understood why she was awake.
*When asked if she was able to choose what time she woke up and went to bed, she said she was not sure.

Review of resident 4's EMR revealed:
*A social service note dated 3/25/21 noted she had been unable to attend her March 2021 care conference meeting because she was participating in bingo.
*There had been no documentation of trying to arrange her care conference meetings around the

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activities she liked to participate in.
*There had been no documentation of trying to include her family or representative to participate in her care conference meetings.

Surveyor 06365:
Interview on 11/18/21 at 12:23 p.m. with the MDS coordinator I revealed:
*"They try to" invite the responsible party by a phone call on the day of the care plan meeting and invite the resident.
*If the resident is out of his/her room at the time, they will leave a note on the resident's bed.
*They have not documented progress notes related to the care plan or meeting.

Interview on 11/18/21 at 2:22 p.m. with the social services designee K revealed she was involved in development of the care plan and attended the care plan meeting but could not provide information about whether the resident and/or responsible party were invited to participate.

Review of the provider's admission packet, updated in November 2016, revealed the resident has the right to:
*Participate in the development and implementation of his/her person-centered plan of care.
*Participate in the planning process, including the right to request meetings and the right to request revisions of the person-centered plan of care.
*Participate in establishing the expected goals and outcomes of the care, the type, amount, frequency , and the duration of the care, and other factors related to the effectiveness of the plan of care.
*Be informed, in advance of any changes in the plan of care.

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F 553	Continued From page 9 *Receive services and/or items included in the plan of care. *See the plan of care, including the right to sign after significant changes to the plan of care. On 11/18/21 at 9:00 a.m., director of nursing services B were requested to meet with the team anytime after 11:00 a.m. to discuss these findings, but she had not come to interview as of 11/18/21 at 3:00 p.m. when administrator A requested the team to leave the building without finishing the survey and having an exit interview.	F 553		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561	1. All residents have the potential to be affected. Resident 182 has discharged from the facility. Resident 29 had a care conference to determine resident preferences prior to 12/22/21. 2. The ED or designee will educate all staff on self determination and resident choice by 12/22/21. All staff not in attendance will be educated by the ED or designee prior to their next working shift. 3. The ED or designee will interview four residents weekly on resident preference or choice to ensure proper interventions are in place weekly times four weeks and monthly times two months. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review or recommendations to continue or discontinue the audits. Addendum: Education was provided to the IDT team on utilizing the MDS/CAA process to individualize resident care plans and educate staff on care plan preferences and individuality. TY/1/4/22.	12/22/21

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§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the provider failed to ensure two of two residents' (29 and 182) preferences had been accommodated. Findings include:

Surveyor 06365:
1. Interview on 11/16/21 at 8:31 a.m. with resident 29 revealed she:
*Sometimes was given a choice for where she eats but was told she had to go the dining room.
*"They got pushy" about her not getting up, but they need to "balance out [my] medications" before she could.
*Had not gotten out of her room to interact with other residents because she had a "fear about running out of oxygen."
*Had received baths only because she insisted on getting one and her "nails are ugly" because they were not taken care of during her last bath.
*Enjoyed coloring and playing games in her room.

Observation of resident 29 during the interview revealed she:
*Grimaced and held her stomach a few times while lying in bed, and explained her stomach was bothering her.
*Was using an oxygen concentrator.
*Had unkempt hair that was not brushed, frizzy, and standing up on end.
*Had long fingernails with dark colored residue under the tips of the nails.
*Had a basket of activity supplies, including

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coloring pages, next to the recliner in her room.

Review of the 10/21/21 admission minimum data set (MDS) assessment in the EMR for resident 29 revealed she:
*Admitted to the facility on 10/15/21.
*Had no difficulties with communication, vision, hearing, or cognitive function.
*Reported it was very important for her to:
-Choose what to wear, her bedtime, and the type of bath.
-Take care of her personal belongings and have a place to lock her things to keep them safe.
-Have snacks between meals.
-Have family involved in discussions about her care and use the phone in private.
-Read, listen to music, be around animals, do things with groups of people, do favorite activities, and participate in religious services.

Review of the resident 29's comprehensive care plan focuses and interventions revealed:
*Activity involvement of "little to no" due to "anxiety, prefer to stay in room and rest," initiated on 10/28/21, had no interventions for:
-Support of in-room activities and keeping her activity supplies safe.
-Oxygen use while attending activities.
*"Establish baseline plan of care," initiated 10/15/21, addessed:
-Bathing "weekly" in "whirlpool" without specifying if that bathing type was her choice.
-Bed mobility but did not specify her choice for bedtime.
-Dressing with no intervention to let her choose what she wanted to wear.
-Grooming without addressing how to provide nail and hair care.
-Meals in "dining room" without offering her a

F 561 Continued From page 12 F 561

choice to eat in her room as she desired nor how she would access snacks between meals.

Review of the progress notes from social services, activities, and dietary revealed there were none that acknowledged her preferences.

Refer to F636, finding 1 and F656, finding 1.

Surveyor 42477:
2. Phone interview on 11/15/21 at 3:40 p.m. with resident 182's representative revealed:
*Resident 182 had been taken to the hospital.
*Resident 182 had been approved for a power wheelchair by the Veterans Administration (VA) hospital.
*The VA completed an evaluation and declared resident 182 to be fit and safe for his motorized scooter.
*The first time he used the power wheelchair in the facility, he ran into the nurse's station and hit his toe.
*The facility took the scooter away.
*He ended up having amputations.
*The facility had not re-assessed him for the use of the power wheelchair.
*The facility put him in a mechanical wheelchair that was too small for him and he had fallen out of it many times.

Interview on 11/18/21 at 11:46 a.m. with therapy director X regarding resident 182's use of his motorized scooter revealed:
*Resident 182 was "a complex resident, with many issues."
*He had failed two evaluations for his power wheelchair.
*One of the times he rammed his toe into the nurses desk causing an opened wound.

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F 561		F 561		

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*Surveyor asked if they would re-evaluate resident 182 for the need of the power wheelchair as it is important to him.
-She had not thought about re-evaluating resident 182 for the power wheelchair.
-She then stated "we could if he returns to the facility."
*She believed his last re-evaluation was approximately mid-September.

Review of resident 182's nursing notes in his electronic medical record (EMR) revealed:
*On 11/8/21 the director of nursing documented:
-Resident 182's wife had called and was upset wanting resident to be able to use his powerwheelchair.
-She had threatened to call the State of South Dakota to complain about this.
-She had been informed that therapy deemed him unsafe with his power wheelchair.

Review of resident 182's therapy notes revealed:
*He was being seen on 11/9/21 due to a report from nursing of him falling out of his wheelchair.
*On 9/5/21 therapy director X documented:
-"Assessed safety with manipulation of electric wheelchair from elevator to nurses station as well as to room with patient extremely unsafe with wheelchair maneuvering in close spaces.
-Recommended no electric wheelchair use until approved by OT (occupational therapy) at this time."

On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and

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F 561	Continued From page 14 requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the	F 565	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey for residents 5, 13, 18, 22 and 24. Resident 19 dis-charged. 2. The ED or designee will educate all staff on providing privacy during a resi-dent group meeting and on follow up to resident concerns/grievances expressed at the resident group meeting by 12/22/21. All staff not in attendance by 12/22/21 will be educated by the ED or de-signee prior to their next working shift. 3. The ED or designee will audit the resi-dent group meeting to ensure privacy was respected and or offereded and proper follow up to the concerns/griev-ances expressed monthly time six months. The ED or de-signee will bring the results of these audits to the monthly QAPI meeting for further review and rec-ommendation to continue or discontinue the audits. Addendum: Staff were educated on us-ing the path through the DNS office to get to offices in the event there is resi-dent council meeting being held. TY/1/4/22.	12/22/21

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families or resident representative(s) of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the provider failed to:
*Provide the resident council with privacy for meetings for six of six residents (5, 13, 18, 19, 22, and 24) who attended.
*Follow-up, investigate, and provide a written response to resident council grievances brought up by the resident council for three of three months of documented meeting minutes.
Findings include:

1. Observations on 11/16/21 at 1:15 p.m. with local long-term care (LTC) ombudsman U revealed no grievance procedure, grievance forms, or identified grievance officer were posted in areas readily accessible to residents, either on the first or second floor of the facility.

Interview on 11/16/21 at 1:30 p.m. with six residents (5, 13, 18, 19, 22, and 24) who attended the resident council group interview, with local LTC ombudsman U present, revealed:
*The resident council met in the large activity room on the second floor.
-The offices for the director of nursing services, social services, and business office manager were located at one end of the meeting space.
-Staff members were observed walking through the activity room, on the side by the offices, during the resident group meeting.
-The resident group confirmed that staff walking through the activity room while the resident council was in session occurred regularly.
-During the meeting, physical therapy assistant (PTA) P approached resident 22 who was

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attending the resident group meeting, with a gait belt and walker in hand. This surveyor stopped the meeting and asked PTA P to leave the room as the meeting was in process. After PTA P left the room, this surveyor resumed the meeting.
*The resident group confirmed that no response or feedback to the group's grievances were received, including:
-Staff responding timely to call lights.
-The lack of activity programs on the weekends.

Interview on 11/16/21 at 3:15 p.m. with social services designee (SSD) K revealed:
*She was the grievance official for the center.
*A request was made for a blank grievance form and SSD K went to the 2nd floor nurses station and tried to locate the form in a file cabinet.
-This surveyor noted a pink binder labeled "Grievances" on the bookshelf behind the nurses station and directed SSD K to this binder.
-SSD K took out a blank grievance form from this binder and gave the form to this surveyor.
*SSD K stated that the last grievance form she received and logged on the grievance log was in July 2021.

Interview on 11/18/21 at 12:05 p.m. with activity assistant J revealed and confirmed:
*She had worked 14 years at this facility.
-Prior position was dietary cook.
-Transitioned to the activity department about six months ago.
-Training to be the provider's activity director.
-Recently completed 40 hours of activity coordinator training.
*She confirmed that staff walking through the activity room during resident council meetings was a normal occurrence.
*She really was not shown how to conduct a

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resident council meeting or complete the "Resident Council Minutes" form and "Grievance Form."
-After the resident council meeting, she fills out the "Resident Council Minutes" form and brings it to administrator A, who "files the form in his office."
-She was not aware of the resident council policy regarding "Concerns brought forth by the Council are resolved via the Center grievance policy" including the filling out of a grievance form.
*She confirmed the ongoing concern from the resident council regarding staff taking too long to answer call lights.
*No activity programming on weekends was due to her being the only staff member in the activity department with no additional activity staff due to resident census.

Further interview on 11/18/21 at 2:22 p.m. with SSD K revealed:
*She had been social service designee since August 2021.
*She received no training from the previous staff member in social services.
*The social worker consultant was at the facility the end of August 2021 for about 4 hours.

Review of resident council minutes from August 2021 through October 2021 revealed:
*On 8/26/21 at 1:35 p.m. discussion included:
-"Call lights on way longer than should be. Understand CNAs [certified nursing assistants] are busy, but they take too long."
-"Saturday-Sunday too long of day with nothing to do. [Resident 13] suggest leave something out to do.
*On 9/28/21 at 2:00 p.m. discussion included "call lights on too long."

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*On 10/26/21 at 2:00 p.m. discussion included:
-"Nursing: don't answer call lights!! Many complaints about that or say they will come back, shut [call] light off and do not come back."
-"Many items missing when changing room."
*All three of these forms were signed by administrator A.

Review of the provider's resident council policy, last updated 1/17 revealed:
*The resident council is intended to promote resident interest and involvement in the center as well as a forum for residents to voice concerns and to suggest changes.
*The center provides a space for meetings, with privacy and staff support.
*Concerns brought forth by the council are resolved via the center grievance policy.
*The center communicates a response and/or decisions to the resident council by the next meeting.

Review of the provider's grievance policy, last updated 11/16 revealed:
*The executive director (ED) and SSD oversees the grievance procedure and coordinates the center system of collecting, tracking, and responding to grievances.
*The center designates a grievance official for the center. Their contact information is posted with the policy in a prominent space.
*The center makes grievance forms and this policy readily available to residents, family members, representatives, visitors, and staff members.
*When immediate resolution is not possible, the grievance is routed to the grievance official and/or SSD within 24 hours. The individual receiving the grievance fills out a grievance form.

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*Social services or designee routes the grievance form to the appropriate department manager, who reviews the grievance, responds within two business days, and returns the grievance form to social services or designee.
*The person with the grievance has a right to a written decision regarding his/her grievance.
*Social services logs grievance forms on the grievance log.
*The ED reviews the grievance log at the daily stand-up meeting for needed resolution and/or follow-up. If a grievance is not resolved in two business days, the ED reviews the grievance daily at the meeting until resolution is obtained.
*SSD analyses grievances monthly for tracking and trending. Identifiable trends are addressed through the Quality Assurance Performance Improvement (QAPI) Committee.

Review of the provider's grievance form, last updated 1/20, revealed the form contained checkboxes that would identify the resident council as an option for where the grievance was received.

Interview with ED to discuss these findings did not occur during the survey.

On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services B to meet with the team anytime after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m. when ED A came and requested the team to leave the building without finishing all survey tasks and interviews or conducting an in person exit interview.

F 572 SS=F Notice of Rights and Rules F 572

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F 572	Continued From page 20 CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure 36 of 36 residents residing in the facility during the survey were informed of resident rights throughout their stay. Findings include: 1. Observations on 11/16/21 at 1:15 p.m. with local long-term care (LTC) ombudsman U revealed no poster of resident rights was posted either on the first or second floor of the facility. Interview on 11/16/21 at 1:30 p.m. with a group of residents during the resident council meeting, with the local LTC ombudsman U, revealed when	F 572	1. All residents have the potential to be affected. 2. The ED or designee will ensure all appropriate signage is posted in the center by 12/22/21. The ED or designee will educate the activity director on reviewing resident rights at the resident group meeting by 12/22/21. 3. The ED or designee will audit that appropriate signage is posted in the center and resident rights are reviewed at the resident group meeting monthly times six months. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

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asked if the facility staff talk about and review the rights of residents in the facility, the consensus of the group was:
*Resident rights were not reviewed or discussed at the monthly resident council.
*The previous staff person who assisted with resident council did review resident rights at their resident council meetings, but this was not currently occurring.

Interview on 11/18/21 at 12:05 p.m. with activity assistant J revealed and confirmed:
*She had transitioned to the activity department about six months ago.
*She was not trained on how to conduct a resident council meeting.
*She was not sure where the poster of resident rights were but stated the facility walls were in process of getting painted and many items were taken off the walls.

Review of provider's resident council minutes form revealed on page 2 of 2 there was a section for discussion of new business. This section included the instruction to "review survey results, locations of required postings, resident's rights, and grievance procedure quarterly. . ."

Review of resident council minutes from August 2021 through October 2021 revealed:
*Under the form's section for Discussion of New Business, nothing was noted in this section on any of the forms for August, September, or October.
*All three of these forms were signed by administrator A.

Review of the provider's resident council policy, last updated 1/17, revealed the only mention of

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F 572	Continued From page 22 resident rights was regarding the right to organize and participate in resident groups reflected in the policy statement. The policy did not address resident rights. Review of the provider's Resident Rights policy, last updated 9/17, revealed a procedure that stated, "The social services director and/or activity director/designee periodically present resident rights information to residents in resident council meetings..." Interview with executive director (ED) to discuss these findings did not occur during the survey. On 11/18/21 at 9:00 a.m. the survey team had requested ED A and director of nursing services (DNS)B to meet with the team anytime after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m. when ED A came and requested the team to leave the building without finishing all survey tasks and interviews or conducting an in person exit interview.	F 572		
F 575 SS=E	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network,	F 575	See next page.	

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F 575	Continued From page 23 home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to display a statement that the resident may file a complaint with the state survey agency. Findings include: 1. Observations on 11/16/21 at 1:15 p.m. on both the first or second floor of the facility with local long-term care (LTC) ombudsman U revealed no statement was displayed with: *How to file a complaint with the state survey agency. *Contact information such as a list of names, mailing address, email address, and telephone numbers. Interview on 11/16/21 at 1:30 p.m. with a group of residents during the resident council meeting and local LTC ombudsman U revealed the group was not aware of their right or given information on how to submit a complaint to the state survey agency about the care they were receiving. Interview on 11/18/21 at 12:05 p.m. with activity assistant J revealed she was not sure if or where the posted information regarding how to submit a	F 575	1. All residents have the potential to be affected. 2. The ED or designee will ensure all signage is posted in the center regarding how to file a complaint with the state survey agency prior to 12/22/21. 3. The ED or designee will audit monthly times six months that the postings are in place. The ED or designee will take the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

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F 575	Continued From page 24 complaint to the state survey agency was but stated the facility walls were in process of getting painted and many items were taken off the walls. Interview with executive director (ED) A to discuss these findings did not occur during the survey On 11/18/21 at 9:00 a.m. the survey team had requested ED A and director of nursing services (DNS) B to meet with the team anytime after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m. when ED A came and requested the team to leave the building without finishing all survey tasks and interviews or conducting an in person exit interview.	F 575		
F 578 SS=F	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578	1. All residents have the potential to be affected. Resident 2, 4, 12, 13, 15, 16, 17, 20, 22, 23, 24, 29, 32, and 37 Advance Directive has been uploaded to their medical record. Residents 26, 27, 28, 182, and 183 have discharged. 2. All Advance Directives will be uploaded to the resident medical record by 12/22/21. The DNS or designee will educate the IDT on documenting review of code status with resident/responsible party and provider, ensuring advance directive is uploaded to the medical chart and all staff know the location of the disaster recovery binder by 12/22/21. All staff not in attendance will be educated by the DNS or designee prior to their next working shift. 3. The DNS or designee will audit weekly times six weeks and monthly times three months that all new admissions have advance directive in the medical record, advance directive is reviewed by family/responsible party and MD quarterly, and staff have knowledge of disaster recovery binder location. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

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F 578	Continued From page 25	F 578		

resident's option, formulate an advance directive.
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the provider failed to ensure 19 of 19 sampled residents' (2, 4, 12, 13, 15, 16, 17, 20, 22, 23, 24, 26, 27, 28, 29, 32, 37, 182, and 183) advance directives had been:
*Available in the medical record.
*Communicated to their physician.
*Periodically reviewed with the resident and/or the resident's representative.
Findings include:

1. Review of the electronic medical records for residents 2, 4, 12, 13, 15, 16, 17, 20, 22, 23, 24, 26, 27, 28, 29, 32, 37, 182, and 183 revealed:
*A statement on the order summary, "For Advanced Directives and Code Status, see

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Disaster Recovery binder at nursing station."
*There was no statement regarding which nursing station the disaster recovery binder was located.
*There were no copies of the advance directives in each resident's electronic or paper medical record.
*When the physicians reviewed residents' current orders, they would not have information about the residents' advance directive and code status without having to referenced the disaster recovery binder.

Review of the disaster recovery binder at the second floor nursing station revealed all of the above residents had forms documenting each resident's advance directives for resuscitative measures. The forms were signed by the residents and/or their representative.

The advance directive form had areas to fill out that included:
*Resident name, physician name, and date.
*Three areas for the resident or resident representative to check including:
-Cardio-pulmonary resuscitation (CPR)/full resuscitative measures.
-No CPR/no resuscitative measures.
-Limited treatment.
*The limited treatment also had areas that could be checked. Those included:
-No CPR.
-Do not intubate.
-No tube feedings.
-No intravenous fluids.
-Do not hospitalize.
-No antibiotics.
-Other/comments.
*Other narratives included:
-"See Resident's medical record for

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documentation and other orders."
-"These directives are the expressed wishes of the resident and/or the resident's responsible party/proxy, are medically appropriate, and are documented in the resident's medical record."
-"I have been informed of and understand the care and treatment options offered. I understand I may revoke these directives at any time. I give permission for this information to be given to physicians, nurses, paramedics, or other health personnel as necessary to implement these directives."

Interview on 11/18/21 at 2:48 p.m. with social services designee (SSD) K revealed she:
*Started this position in August 2021, but was not sure of her actual start date.
*Would review the advance directive form when a resident was admitted. If the resident and/or representative had questions she could not answer, she would consult with other staff.
*Had been informed approximately one year ago, before she became the SSD, that the resident's code status was not able to be listed in their EMR. They were removed from all residents' EMRs at that time.
*Agreed if a resident's advance directive/code status was needed, staff would have to look in the disaster recovery binder at the second floor nurses station.
*Confirmed there was no disaster recovery binder at the first floor nurses station.

On 11/18/21 at 9:00 a.m., the executive director A was requested to provide a copy of the advance directive policy. At 1:46 p.m., ED A reported they had no policy and referred to "patient preference and state requirements."

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On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services B to meet with the team anytime after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m. when ED A came and requested the team to leave the building without finishing all survey tasks and interviews or conducting an in person exit interview.

F 580 SS=D Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) F 580

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the

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F 580	Continued From page 29 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to notify resident's representatives of changes for two of two sampled residents (182 and 183). Findings included. 1. Phone interview with resident 182's family representative revealed that the provider had not kept her up to date on status of his wounds while he had resided in the facility. Observation of the resident was not possible as he was curently in the hospital. Review of resident 182's record revealed he had multiple wounds before being transferred to the hospital. Refer to F686, finding 1.	F 580	1. All residents have the potential to be affected. Resident 182 and 183 have discharged from the center. 2. The DNS or designee will educate all licensed nursing staff on notification in change to responsible party by 12/22/21. All staff not in attendance will be educated prior to their next working shift by DNS or designee. 3. The DNS or designee will audit a random sample of four residents for proper notification of responsible party due to change in condition weekly times six weeks and monthly times three months. The results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue of discontinue the audits.	12/22/21

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F 580	Continued From page 30 2. Phone interview with resident 183's family representative revealed that the provider had not informed him of any changes. Every time he called, he was told his grandfather was doing "good." Observations of resident 183 during the survey from 11/15/21 through 11/18/21 revealed he had been experiencing restlessness, pain, and difficulty in eating and drinking. Review of the record revealed multiple gaps in timely nursing assessment and documentation. Refer to F600, finding 1. On 11/18/21 at 9:00 a.m., the executive director (ED) A was requested to provide a copy of the provider's policy regarding notification of changes to the physician and resident representative. At 1:46 p.m., ED A noted a written clarification "in regards to what?" about the requested policy. On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 580		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		

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F 585	Continued From page 31 furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 585	1. All residents have the potential to be affected. Resident 13 and 29 have been interviewed regarding missing items. Resident 27 has discharged from the facility and has been attempted to be contacted regarding missing item. 2. The DDCO will educate the IDT on the grievance policy by 12/22/21. The ED or designee will educate residents on the grievance process and where to locate the form to file a grievance by 12/22/21. 3. The ED or designee will audit all grievances weekly times four weeks and monthly times two months to ensure timely follow up on resident concerns/ grievances. The ED or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	12/22/21

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(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency

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confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and admission packet review, the facility failed to:
*Make information about how to file a grievance and the grievance forms readily available to residents and their responsible parties.
*Provide resolutions to 3 of 13 residents (13, 27, and 29) who had reported grievances.
*Provide resolutions to the resident council for 3 of 3 council minutes reviewed.
Findings include:

1. Review of the provider's admission packet, updated in November 2016, revealed the grievance procedure policy specified:
*The administrator and social services designee (SSD) "oversees the grievance procedure."
*Contact information for the designated grievance official is "posted with the policy in prominent areas throughout the center."
*Grievance forms are "readily available to residents, family members, resident representatives, visitors, and staff members."
*When "immediate resolution is not possible, the individual receiving the grievance fills out a grievance form."
*SSD "routes the grievance form to the appropriate department manager, who reviews the grievance, responds within two business days, and returns" it to the SSD.
*The policy does not specify who is responsible to communicate the resolution to the person filing

F 585 Continued From page 34 F 585

the grievance.
*Grievance forms and investigations "are maintained for a minimum of 3 years."

Observation throughout the facility did not reveal grievance official contact information, policy, nor forms in prominent locations that would be readily available to anyone with a grievance.

Interview on 11/16/21 at 3:15 p.m. with SSD K revealed she was not aware of the location of the grievance forms.

2. Interviews on the dates and times listed below with three sampled residents (13, 27, and 29) revealed they each had personal belongings go missing, they reported the missing items to someone, and had not received a report on the investigations or resolutions to their missing items:
*11/16/21 at 10:07 a.m., resident 13 said he discovered a couple of month ago that money was missing from an envelope he kept in his bedside drawer, and it "wasn't a lot but enough to notice."
*11/16/21 at 9:14 a.m., resident 27 said he was missing a "brand new pair of jeans that my daughter bought for me along with a pair of green pants" when he moved into the facility a month ago. He was wearing the green pants and explained they "came back from laundry but the jeans did not."
*11/16/21 at 8:45 a.m., resident 29 said she was missing a permanent black marker that she used for marking her personal belongings and a pink pen like a stylus with a rubber tip on one end and a pen on the other.

Review of the minimum data set (MDS)

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assessments in the electronic medical record (EMR) for the same four sampled residents revealed:
*9/14/21 quarterly MDS, resident 13 was coded as cognitively intact with no communication limitations.
*10/22/21 admission MDS, resident 27 was coded as cognitively intact with minimal difficulty hearing but had no communication limitations.
*10/21/21 admission MDS, resident 29 was coded as cognitively intact with symptoms of inattention and trouble concentrating but without communication limitations.

Review of the grievance binder and interviews with executive director A and SSD K did not occur regarding these specific reported grievances.

On 11/18/21 at 9:00 a.m., administrator A and director of nursing services B were requested to meeting with the team anytime after 11:00 a.m. to discuss these and other findings, but they had not come to interview as of 11/18/21 at 3:00 p.m. when administrator A requested the team leave the building without finishing the survey and having an exit interview.
3. Interview on 11/16/21 at 1:30 p.m. with a group of residents during the resident council meeting, with local long term care ombudsman U, revealed the group had received no response or feedback to the group's grievances. Refer to F565, finding 1.

F 600 SS=J Free from Abuse and Neglect | F 600
CFR(s): 483.12(a)(1)

§483.12 Freedom from Abuse, Neglect, and Exploitation
The resident has the right to be free from abuse,

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F 600	Continued From page 36 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; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (12 and 183) had received care in a manner to prevent abuse and/or neglect for residents who were dependent on staff to meet their needs. Findings include: Surveyor 45383: 1. Interview on 11/15/21 at 8:30 a.m. with licensed practical nurse (LPN) E revealed she did not have any dressing changes for the surveyors to observe that day. Surveyor 42477: Observation on 11/15/21 at 8:53 a.m. of resident 183 revealed he had: *Been in a hospital gown. *Only had a thin draw sheet covering him. *Been laying on his back. *A phlegmy cough. *His bed lowered to the floor and had a fall mat on the floor, next to his bed. *His catheter bag was on the floor. Observation on 11/15/21 at 10:22 a.m. of resident	F 600	1. All residents have the potential to be affected. Residents 12 and 183 have discharged from the facility. 2. The DNS or designee educate all licensed nurses on following physician orders for treatments and notifying provider for alternative dressing change if supplies are not available, documentation of supply in-availability, admission evaluations are completed, pain assessments are completed, recognizing signs/symptoms of pain, ADL cares, catheter care, dressing in regards to dignity, grooming, bed baths, oral care in regards to pocketing of food, catheter care and treatment of pain, also, on utilizing the 24 hour report in PCC to give shift to shift report and relaying pertinent information to the NA's and CNA's. Educate all nursing staff on turning and repositioning for residents at risk and with breakdown. Educate CNA's and NA's on recognizing signs/symptoms of pain, ADL cares, catheter care, dressing with dignity, grooming, bed baths, oral care specifically pocketing of food, and catheter care by 12/22/21. All staff not in attendance will be educated prior to their next working shift. 3. The DNS or designee will audit on ensuring preventative measures are in place to prevent skin breakdown on residents with and without wounds, peri-care completed timely and resident is clean and dry residents with incontinence are checked every one to two hours, treatments done as ordered and changed if no improvement in wound noted per provider direction or every 14 days as stated in policy, (continued)	12/22/21

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F 600	Continued From page 37 183 revealed: *He had been lying on his back. *His catheter bag was still touching the floor. *He had still been wearing a hospital gown. *Only had a thin sheet covering him. *He did not have any food or drinks near him. Observation and interview on 11/15/21 at 1:35 p.m. with resident 183 and registered nurse (RN) D revealed: *She was going to give resident 183 a suppository because "Hospice told her to." *Resident 183 was lying in bed, wearing only a disposable brief. *His thin sheet had not been covering him. *His room door was opened, his curtain had been pulled back. *Surveyor asked RN D if resident 183 had clothes. -She was unsure if resident 183 had clothes or where the clothes might be. -She thought they were in the laundry. *RN D stated that his mouth was full of "crud." -She used a toothette to moisten his lips. -She had not used the toothette to clean out his mouth. *Surveyor asked who his hospice provider was. -RN D was not "quite sure" who his hospice provider was. -There was no information about him in their hospice binder. Surveyor 45383: Observation and interview on 11/16/21 at 8:25 a.m. of resident 183 with RN H revealed: *He had many dry patches of skin in his mouth. *His tongue had been dried and cracked. *His lips were dry. *Surveyor asked RN H about observing his	F 600	family notification, physician notification, and dietician notification with assessment and knowledge of staff of who has wounds on their unit, admission evaluations are completed, pain assessments are completed, recognizing signs/symptoms of pain, ADL cares, catheter care, dressing with dignity, grooming, bed baths, repositioning, oral care specifically pocketing of food, and catheter care weekly times four weeks and monthly times four months. The DNS or designee will take the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. Addendum: Education included following all orders, including those from hospice. TY/1/4/22.	

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

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dressing changes. She replied, "If I get to it, it will be this afternoon."
*Dressing change was completed on 11/16/21 at 11:20 a.m.

Observation on 11/16/21 at 9:29 a.m. of resident 183 revealed:
*His mouth was still dry.
*His tongue was still dry and cracked.
*He was laying on his back with only a brief on.
*His lips were still dry and chapped.

Surveyor 42477:
Phone interview on 11/16/21 at 8:52 a.m. with hospice RN M about resident 183 revealed:
*He had been admitted to Hospice care while he was at the hospital on 11/12/21.
*He had been admitted to the facility on 11/12/21.
*Hospice providers had not seen him in the facility since his admission.
*RN M was on her way to the facility to see resident 183.
*She stated they received a call from the facility yesterday about holding medications and giving him a suppository for constipation.
-They had not received any other calls from the facility regarding resident 183.
*She would touch base with the surveyors after she visited with resident 183.

Interview on 11/16/21 at 11:30 a.m. with hospice nurse RN M revealed:
*She ended up getting eight toothettes of old ground-up food and gunk out of his mouth.
*It had appeared that oral care had not been done as he had a lot of ground beef packed in his mouth and he had not been eating recently.
*With all the ground meat and gunk she wiped out of his mouth she could understand why he

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had trouble swallowing.
*His mouth was so dry the left side of his lip had split open.
*They gave him orange juice which is acidic and would irritate his already sensitive mouth.
*He had been on his back when she arrived.
*She asked staff about his order to turn and reposition every two hours.
-Staff were not sure about the order.
*His back had been red from being on it for so long.
*In 23 years of nursing she had never seen what she determined was "such a bad case of neglect from a lack of cares."
*Nursing informed her today that he was very restless yesterday, she inquired if they had given him anything.
-They gave him one dose of his lorazepam medication.
-He can have it every hour.
*She had to go over the dressing and wound care orders with RN H.
-It had been apparent that she was not aware of the orders.
*His dressings had not been changed at all on 11/15/21.
*The wound on his sacrum had leaked necrotic fluid through the dressing and to his brief.
*She provided education to RN H stating that the dressings were for comfort, it was not for treatment of the pressure ulcers.
*RN H had changed his dressing with RN M in the room.
*He had been in pain while this dressing change was being completed.
*The odor was very strong and pungent of necrotic tissues.
*RN M inquired about the resident having a blanket and clothes.

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F 600	Continued From page 40 *He had only been wearing an incontinence brief when she arrived. *RN H had not been aware if he had clothing. *Resident 183's catheter had been wrapped around the bed and pulled super tight at the insertion site. *RN M found out that they had not been giving resident 183 his pain medication as ordered. *His hair appeared greasy and had not appeared to have received a bath. *RN M stated she would call and update his family. *RN M called and received a verbal order for a Fentanyl patch for resident 183. -She applied the patch and let RN H know that it would take about 12 hours to start working so they would need to supplement his other pain medication. Interview on 11/16/21 AT 2:02 p.m. with divisional director of clinical operations (DDCO) C, executive director (ED) A, and director of nursing services (DNS) B revealed: *Regarding ensuring residents had clothing to wear: -If a family was admitted without clothes, they have a surplus they can use. -Social services would reach out to the family to see if they could bring in items. -ED A will also buy items if they are unable to obtain any clothes. *As far as ensuring admission assessments are completed: -DNS B states that they do not have a very good admission process. -The nurses are expected to take care of the admission assessments within 24 hours of admission. -Typically, there is a dashboard that pops up in	F 600		

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F 600	Continued From page 41 the electronic medical record (EMR) to let them know they need to complete the admission assessment. -DNS B is responsible for ensuring admission assessments are completed. -DNS B admits this process has not been great due to the COVID-19 survey last week and they have had admissions and hospitalizations. *Regarding how hospital orders are implemented into resident's plans of care: -They document in the resident's progress notes. -They follow the hospital admission orders. *Regarding the newly admitted baseline care plans: -DNS B tried to get them done as soon as possible. -All staff can add to the 48 hour baseline care plan. -DNS B usually trys to talk to the families about the resident's care plans. --She then waits until the families come into the facility to have them sign the baseline care plan. -The care plan is placed in a binder that staff can look at every day. *Regarding communication between shifts: -There is a tape recorder that nurses record shift reports on. -There is a communication binder that is kept at the nurses' station. *Regarding ensuring residents are receiving required cares: -Certified nursing assistants (CNAs) are to be documenting their tasks in the resident's EMR. -Things on the medication administration record (MAR)/ treatment administration record (TAR) is to be completed by nurses. *They have daily monitoring of pain. *They have daily rounds. *If someone were to be restless or agitated, they	F 600		

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receive pain medication.
*Nurses are supposed to oversee the aides to ensure residents are receiving the care they deserve.
*They have mostly all senior nurses on shift.
*DNS B believed nurses had been monitoring baths, skin checks, vitals, and blood pressure checks.
*CNAs document baths and bed baths in the residents' EMR.
*The main bath aide completes the skin checks, baths, vitals, and blood pressures during the resident's baths.
*Licensed nurses are supposed to go in to observe the resident's skin while they are receiving their baths.
*Oral care, bathing, and dressing was also documented in the residents' EMR.
*DDCO C stated if residents are non-compliant, the non-compliance would be documented.
*Regarding resident 183, he was already on hospice due to the hospital contacting hospice.
*Hospice has always been very quick with getting back to the facility regarding orders.
*In order to communicate with hospice, they have a special hospice binder.

On 11/16/21 at 2:52 p.m. while surveyor was conducting a staff interview for a separate investigation, the staff member's walkie talkie sounded with a staff member stating resident 183's family member was on the phone and wanted to see how he was doing. RN H said into the walkie talkie, "Good, he's been in bed all day."

IMMEDIATE JEOPARDY HARM
Resident had food debris impacted in his mouth making him unable to take in food or swallow his medications and resulted in a split lip on the left

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corner of his mouth. The resident exhibited pain with dressing changes, grimacing, groaning, and restlessness. His back was red from being left lying on his back. His catheter was wrapped tightly around the bed and was pulling at the insertion site. Two unstageable wounds had not been treated in 36 hours with a moderate amount of green exudate that leaked through the dressing down to his brief. A strong odor was present. He was noted to only have an incontinent brief on covered by a thin sheet.

IMMEDIATE JEOPARDY NOTICE
On 11/16/21 at 5:06 p.m. and immediate jeopardy had been determined when the facility failed to ensure:
*Physician orders had been implemented and an admission assessment had been completed to identify the care and services needed for a resident related to:
-Oral care.
-Pain, agitation, and restlessness.
-Personal hygiene.
-Repositioning.
-Treatment of wounds.
-Professional standards for other quality of care needs to achieve his highest practicable level of well--being.

ED A, DNS B and DDCO C were asked for an immediate removal plan.

IMMEDIATE JEOPARDY REMOVAL PLAN:
On 11/17/21 at 12:37 p.m. the DDCO C, ED A, and DNS B provided the survey team with an email that included the final written removal plan. The written removal plan was approved by the long-term care advisor for the department of health on 11/17/21 at 12:58 p.m.

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The facility provided the following acceptable removal plan on 11/17/21:
"1. Educate ED and DNS on auditing that physician orders were following and treatments were completed, admission evaluations are completed, pain assessments are completed, recognizing signs/symptoms of pain, ADL cares, catheter care, dressing, grooming, bed baths, oral care, catheter care and treatment of pain by DDCO (Divisional Director of Clinical Operations). The ED/DNS or designee will educate all licensed nurses on the following physician orders for treatments and notifying provider for alternative dressing change if supplies are not available. documentation of supply in-availability, admission evaluations are completed, pain assessments are completed, recognizing signs/symptoms of pain, ADL cares, catheter care, dressing in regards to dignity, grooming, bed baths, oral care in regards to pocketing of food, catheter care, dressing in regards to dignity, grooming, bed baths, oral care in regards to pocking of food, catheter care and treatment of pain, also, on utilizing the 24 hour report in PPC [Point Click Care] to give shift to shift report and relaying pertinent information on the NA's [nursing aides] and CNA's [Certified nurse aide]. Educated all nursing staff on turning and repositioning for residents at risk with breakdown. Educate CNA's and NA's on recognize the signs/symptoms of pain, ADL cares, catheter care, dressing with dignity, grooming, bed baths, oral care specifically pocketing of food, and catheter care. Education provided by Divisional Director of Clinical Operations to ED and DNS. They, in turn, will educate all nursing staff prior to their next working shift by 11/16/21 at 11:59 p.m."
"2. An audit will be conducted on ensuring

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preventative measures are in place to prevent skin breakdown on residents with and without wounds, peri-care completed timely and resident is clean and dry residents with incontinence are checked every one to two hours, treatments done as ordered and changed if no improvement in wound noted per provider direction or every 14 days as stated in policy, family notification, physician notification, and dietician notification with assessment and knowledge of staff of who has wounds on their unit, admission evaluations are completed, pain assessments are completed, recognizing signs/symptoms of pain, ADL cares, catheter care, dressing with dignity, grooming, bed baths, repositioning, oral care specifically pocketing of food, catheter care, and knowledge of the report process. The DNS or designee will be responsible for the audits. The audits will be completed 4 times weekly times four weeks, bi-monthly times two months or until substantial compliance is met."
"3. Compliance date 11/16/2021."

The immediate jeopardy had been removed on 11/18/21 at 3:00 p.m. after verification that the provider had implemented their removal plan. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "G."

Review of resident 183's nursing notes in his EMR revealed:
*He arrived at the facility on 11/12/21 at 2:45 p.m. via ambulance.
-He was documented to be in pain from the ride to the facility.
*He was administered pain and anxiety medication seven hours later at 11/12/21 at 9:49 p.m.
*On 11/12/21 at 10:23 p.m. documentation

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reflected:
-He had eaten 15 percent of his supper.
-He was pocketing his food.
*On 11/13/21 at 3:31 p.m. and 3:32 p.m. he received medication for pain and axiety.
*On 11/13/21 at 11:39 p.m. documentation reflected he had "taken a few bites Refuses his meals & he pocketed..."
*On 11/15/21 documentation reflected he was to be repositioned and given "some good skin care."
*There had been no documentation of communication with hospice or phone calls to hospice.

Review of resident 183's November 2021 MAR revealed he had orders for 19 medications for pain, anxiety, cramping, and constipation.
*The Wong- Baker pain assessment had not been added to his MAR.

Review of resident 183's hospital documentation revealed:
*He had been admitted to the hospital on 11/6/21.
*The physician documented:
-"...admitted for 2 decubitus ulcers one on his sacrum as well as one on his left heel both which are unstageable. Based on the size and degree of the ulcers this is likely been going on for sometime and he is likely receiving suboptimal care at his facility..."
*He also had:
*Deep vein thrombosis (DVT).
*Acute Kidney Injury.
*Cellulitis infection surrounding the sacrum ulcer.
*On 11/9/21 the hospital debrided the sacrum ulcer and heel ulcer.
*On 11/9/21 the physician spoke with resident 183's family member and they opted to go comfort cares/palliative care.

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*The family member had to find a new facility, and had not wanted to send him back to the facility he was at previously.
*They found placement and discharged him to new facility on 11/12/21.
*They noted that he would be transported by ambulance because trying to transport him in a car would put too much pressure on his sacrum ulcer and would be exceptionally painful.

Review of resident 183's discharge orders revealed:
*He was to receive:
-"Sacrum: Packing/Dressing, change twice daily. Remove previous dressing, cleanse with wound spray and gauze. Pack wound cavity and cover entire wound with Vashe-moistened gauze. Cover with ABD [army battle dressing] and secure with medipore tape."
-"Turn and reposition Q2-4H [every 2 to 4 hours] as tolerated by patient. Apply isogel air mattress with pump. Apply chair cushion if up to chair."
-"Left heel: Dressing change daily. Apply betadine-soaked gauze over left heel wound, then cover with loosely rolled on kerlix or roll gauze and loosely applied ACE wrap. Offload heels at all times."

Review of resident 183's admission assessment revealed:
*His 11/12/21 at 2:45 p.m. admission assessment vitals had been documented.
*The remaining 13 pages were blank.
*As of 11/16/21 at 12:16 p.m., his admission assessment had not been completed.

Review of resident 183's November TAR revealed:
*Turning and repositioning was not listed for staff

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to complete.
*He had not received any dressing changes on 11/15/21 to his heel or to his sacrum ulcer.

Review of resident 183's bathing documentation revealed as of 11/16/21 at 12:31 p.m. no baths had been documented.

Review of resident 183's EMR revealed turning and repostioning had not been added so staff could ensure that resident 183 had been turned and repositioned every two to four hours.

Phone interview on 11/17/21 at 1:25 p.m. with resident 183's power of attorney (POA) revealed:
*His grandfather (resident 183) had been transferred to the facility on 11/12/21.
-This had been after they found out he was not receiving adequate care at another facility.
*He said he was "stuck between a rock and a hard place" and had to pick a new skilled nursing facility for his grandfather to live.
*He saw his grandfather on Saturday 11/13/21.
-He was sitting up in bed, eating beef pot roast or beef roast or beef pot pie.
*His grandfather had not been wearing any clothes so he and his wife ran to the store to buy him three shirts and three pairs of pants.
*He calls the facility every day, if not twice per day.
-He verified he called on 11/16/21 around 2:45 p.m., and was told everything was good.
*He received a call from the hospice provider yesterday to update him.
*The facility called him today to let him know his grandfather was declining so he was on his way to the facility during the phone interview.

Surveyor reached out to medical director HH. He

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was unavailable for a phone interview.

Review of the provider's Admission/Readmission Nursing Evaluation form for resident 183 revealed document that consisted of 14 pages that when completed was a head-to-toe assessment and multiple body system review. The only area that had been completed for resident 183 was a portion of the general assessment that included the resident's vitals, the remain 13 pages had not been completed.

Review of the provider's June 2016 Pain Management policy revealed:
*"Residents' pain level is evaluated every shift by the LN [licensed nurse]. Noted pain is evaluated and treated accordingly by the LN. Pain is also evaluated quarterly and PRN [as needed]using the RAI [resident assessment instrument]/nursing process. Pain level is monitored and documented on the MAR using the Wong-Baker pain scale."
*"When pain is not adequately controlled by current regimen, or if there is newly identified pain, the LN contacts the physician for consideration of new or modified treatment orders."
*"The information on the Pain Evaluation Record is used in conjunction with the Center's other evaluation and data collection tools to develop an individualized care plan, including non-pharmaceutical interventions, if appropriate."
*"If the resident is a hospice client or receiving palliative care/comfort care, the LN and hospice personnel collaborate to develop and evaluate the pain management Plan of Care (POC)."

Review of the provider's September 2017 Hospice Provision of Care by Outside Providers policy revealed:

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*"Centers collaborate with outside providers to coordinate the provision of hospice care as directed by each resident's physician."
*"The hospice and Center communicate, establish, and agree upon a coordinated Plan of Care (POC) reflecting the hospice philosophy and based on an evaluation of the individualized needs of the resident. The POC includes: directives for managing pain and other uncomfortable symptoms, the care and services the Center and hospice provide in order to be responsive to the unique needs of the resident and his/her expressed desire for hospice care. The hospice retains overall professional management responsibilities directing the implementation of the POC related to the terminal illness and associated conditions. The POC is updated quarterly and as needed."
*"The Center offers the same services to residents who have elected hospice benefits as to residents who have not elected hospice benefits. Residents have the right to refuse hospice services."
*"Prior to admission of a resident receiving hospice services by an outside provider, service coordination is agreed upon indicating each party's responsibilities. This may include, but is not limited to: medications, DME, laboratory services, and notifying physicians."
*"The Center immediately notifies hospice of all allegations of: a. Mistreatment. b. Neglect. c. Verbal, mental, physical, or sexual abuse. d. Injury of unknown origin. e. Misappropriation of property by hospice personnel. f. Exploitation."

Review of the provider's 10/19/18 hospice agreement with the hospice provider revealed:
*"WHEREAS, The Facility desires to assure that the highest quality and level of services are

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F 600	Continued From page 51 provided to such individuals with respect to the care and management of their terminal illness." *"The facility shall furnish to the individual who is both a resident of The Facility and a Hospice client all of those services which normally would have provided in the absence of The Hospice Program, as provided for in The Facility policies, procedures, protocols, and agreements with the resident and the resident's family. It is understood and agreed that because of the eligible resident's place of residence is The Facility, The Facility shall provide those services which approximate the kind of services which would have been provided by family members." *"With respect to the management of the resident's terminal illness, The Facility shall:" -"1. Notify The Hospice in the event of changes in the resident's condition; and" -"2. Provide usual and customary services of The Facility subject to The Hospice Plan of Care for such a resident including: Performing personal care services, Assisting with ADL [activities of daily living], Administering medication, Socializing activities, Maintaining the cleanliness of the resident's room, Supervising and assisting with the use of DME[durable medical equipment] and prescribed therapies." -"3. Make records pertaining to care and services furnished by The Facility to a Hospice client available to The Hospice subject to the resident/client's consent." Review of the provider's September 2017 Abuse, Corporal Punishment, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Resident's Property, and Exploitation policy revealed: *"Each resident has the right to be free from abuse, including verbal, mental, sexual, or	F 600		

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F 600	Continued From page 52 physical abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, misappropriation of resident property, exploitation, and any physical or chemical restraint not required to treat the resident's medical condition. The Center implements policies and processes so that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members, and others who may have unsupervised access to residents. These policies address screening, training, prevention, identification, investigation, protection, and reporting/response." *"Deprivation of Goods or Services by Staff: The deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. In these cases, staff has the knowledge and ability to provide care and services, but choose not to do it, or acknowledge the request for assistance from a resident(s), which result in care deficits to a resident." *"Neglect: Failure of the Center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." *"Mental abuse: The use of verbal or non verbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. It includes but is not limited to, coercion, harassment, inappropriately isolating a vulnerable adult from family, friends, or regular activity, and verbal assault that includes ridiculing, yelling, or swearing. Examples of verbal or nonverbal conduct that can cause mental abuse, include but are not limited to, staff taking photographs or recordings of residents that are demeaning or humiliating using any type of	F 600		

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equipment (e.g. cameras, smart phones, and other electronic devices) and keeping or distributing them through multimedia messages or on social media networks."
*"Verbal Abuse: May be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communications, or sounds, to residents within hearing distance, regardless of age, ability to comprehend or disability. Examples of mental and verbal abuse include, but are not limited to: Harassing a resident; Mocking, insulting, ridiculing; Yelling or hovering over a resident, with the intent to intimidate; Threatening residents, including but not limited to depriving a resident of care or withholding a resident from contact with family and friends; and isolating a resident from social interaction or activities."
2. Interview on 11/16/21 at 8:20 a.m. with resident 12 regarding her insulin administration and interaction with nurses revealed:
*She stated that she had to argue with nursing staff to get her blood sugar and insulin given at the right time.
*She had been experiencing shaking when her insulin was given at 8:30 a.m., 12:30 p.m. and 4:30 p.m.
*Staff had not rechecked her blood sugar.
*Mealtimes were:
-7:00 a.m. continental breakfast (juice and a muffin).
-10:00 a.m. breakfast.
-1:00 p.m. lunch.
-5:00 p.m. supper.
-8:00 p.m. evening snack.
*She spoke with nursing about her shaking and how she should not be given her insulin 1 hour before meal times.
*She stated staff were rude and upset with her

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F 600	Continued From page 54 when she refused to let them administer insulin too early. *Staff would make remarks about her snacking and her blood sugar being elevated. Interview on 11/16/21 with licensed practical nurse (LPN) E revealed: *Had been a been a nurse for 50 years. *Received yearly training on medication administration and insulin. *Had not received any advanced diabetic education. *Had not received any customer service training and thought that referring to residents as customers was a "cold term." Review of 9/12/21 at 7:55 a.m. nursing progress note for resident 12 composed by LPN E revealed: *Resident's blood sugar was 234. *She had a lot of regular coke on her bedside stand. *Was instructed she should drink diet coke. *She was instructed to watch what kind of snacks such as crackers which are full of carbohydrates. *Resident was already aware of this information. Review of 11/5/21 at 1:15 p.m. nursing progress note for resident 12 composed by LPN E revealed: *Resident was in her wheelchair by the nurses desk. *Acknowledged LPN E coming with the charge cart. *Informed LPN E she was not going to eat and did not need that. *Her husband was there and she was "going out to smoke." *Informed resident that she should make her	F 600		

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F 600	Continued From page 55 diabetes the priority instead of smoking, and skipping meals and insulin was not a good idea. *Resident wheeled by with no comment. Review of resident 12's care plan initiated on 9/22/21 revealed: *I have inappropriate snacks in my room and have been educated about correct. *I prefer to continue to eat my snacks. Review of providers Abuse Policy dated September 2017 revealed: *Mental abuse is the use of verbal and nonverbal conduct which causes or the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. *Verbal abuse is a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance. On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services (DNS) B to meet with the team anytime after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m. when ED A came and requested the team to leave the building without finishing all survey tasks and interviews or conducting an in person exit interview. Interview with DNS B would have included: *How staff were expected to communicate with residents who make questionable choices about their health conditions. *What actions she would take regarding the manner in which LPN E interacted with resident 12.	F 600		

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F 625 SS=F	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide notice of bed hold for four of four sampled residents (13, 28, 29, and 37) discharged to the hospital. Findings include: 1. Interview on 11/18/21 at 10:45 a.m. with resident 28 revealed he had not received any	F 625	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The ED or designee will educate the IDT team and all licensed nursing staff on offering a bedhold upon hospital tran-fer to resident or responsible party by 12/22/21. All staff not in attendance will be educated prior to their next working shift by the ED or designee. 3. The ED or designee will audit all hos-pital transfers for offering of a bed-hold upon transfer or discharge weekly time four weeks and monthly times two months. The ED or designee will take the results of these audits to the monthly QAPI meeting for further review and rec-ommendation to continue or discontinue the audits.	12/22/21

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information on a bed hold when he had been hospitalized.

Review of resident 28's medical record revealed:
*He had been hospitalized on 8/20/21 and returned on 8/24/21, on 9/27/21 and returned on 9/29/21, and on 10/8/21 and returned on 10/14/21.
*There was no signed bed hold in his record.

Interview on 11/18/21 at 12:16 p.m. with social services designee K revealed:
*When a resident was admitted they signed the admission paperwork.
*That paperwork had a blanket bed hold that was good for all hospitalizations or leave of absences.
*She was not aware a bed hold had to have been given to the resident and/or their representatives for each hospitalization or leave of absence.

2. Review of minimum data set (MDS) assessments for residents 13, 29, and 37 revealed they had been recently hospitalized and returned:
*Resident 13 transferred on 10/12/21 and returned on 10/14/21.
*Resident 29 transferred on 11/10/21 and returned on 11/12/21.
*Resident 37 transferred on 10/12/21 and returned on 10/14/21.

Review of electronic medical records for these residents did not reveal any bed hold notices.

Interview on 11/18/21 at 10:40 a.m. with business office manager DD revealed the bed hold policy is provided to residents at the time of admission. They do not provide one at the time of transfer.

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F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in	F 636	1. All residents have the potential to be affected. Resident 12, 22, 29 and 37 have had a new CAA completed. Resident 27 has discharged. 2. The Divisional MDS Coordinator will provide CAA training to the IDT team prior to 12/22/21. 3. The DNS or designee will audit all CAA's completed weekly times four weeks and monthly times five months. The DNS or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	12/22/21

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assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to document comprehensive person-centered assessments that included needs, strengths, and preferences for four of eight sampled residents (12, 22, 27, 29, and 37) reviewed for completion of comprehensive assessments. Findings include:

1. Interview on 11/16/21 at 8:31 a.m. with resident 29 revealed she:
*Sometimes was given a choice for where she eats but was told she had to go the dining room.
*Wants to "get back to getting up and going" after her recent return from the hospital.
*"They got pushy" about getting up but they need

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to "balance out [her] medications" before she can.
*Needs help using the toilet so she does not trip on her oxygen tubing.
*Had not gotten out of her room to interact with other residents because she had a "fear about running out of oxygen."
*Not getting out of her room to interact with others because she thought someone asked here why she was wasting oxygen when the resident she was using an oxygen tank in the therapy room.
*Had not gotten her hair styled since the stylist had not come "because of COVID."
*Had received bathes only "because of my nasty attitude" and her "nails are ugly" because they were not taken care of during her last bath.
*Enjoyed coloring and playing games in her room.

Observation of resident 29 during the interview revealed she:
*Grimaced and held her stomach a few times while lying in bed, and explained her stomach was bothering her.
*Was using an oxygen concentrator.
*Had unkempt hair that was not brushed, frizzy, and standing up on end.
*Had long fingernails with dark colored residue under the tips of the nails.
*Had a basket of activity supplies, including coloring pages, next to the recliner in her room.

Review of the 10/21/21 admission minimum data set (MDS) assessment in the electronic medical record (EMR) for resident 29 revealed she:
*Entered the facility on 10/15/21.
*Had no difficulties with communication, vision, hearing, or cognitive function.
*Had symptoms of inattention and trouble concentrating that was present continuously over the two weeks prior to 10/21/21.

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*Needed physical help transferring between surfaces and moving about with her walker and wheelchair.
*Reported it was very important for her to:
-Choose what to wear, her bedtime, and the type of bath.
-Take care of her personal belongings and have a place to lock her things to keep them safe.
-Have snacks between meals.
-Have family involved in discussions about her care and use the phone in private.
-Read, listen to music, be around animals, do things with groups of people, do favorite activities, and participate in religious services.
*Participated in the admission MDS.

Review of the care area assessment (CAA) worksheets completed with the 10/21/21 admission MDS revealed none of CAA worksheets included the resident's and her family's input regarding each care area, the resident's fear of being without oxygen, nor what she had reported as very important customary routines and activities.
*The cognitive loss CAA addressed her problem with inattention but only noted the related diagnoses of depression and anxiety and her current medication.
*The activities of daily living (ADL) CAA did not note an evaluation of the problems for each ADL nor address goals regarding:
-Dressing, her preference for obtaining what she wants to wear.
-Bathing, her preferences for the type of bathing and grooming of her hair and nails.
-Toileting and transfer, self-sufficiency related to the impact her oxygen use had on her abilities.
-Eating, her preference to have snacks between meals.

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*The activities and psychosocial well-being CAAs both had the same problem note as the cognitive loss CAA, but did not check any:
-Relationship factors that could be modified.
-Customary lifestyle routines to maintain.
-Strengths to build upon such as activities that put the resident at ease, gave a sense of satisfaction, and distinguished the resident before admission.
-Activity preferences and pursuits such as solitary activities, inside the home, or self-directed.
-Environmental and other issues that hindered activity participation, such as her need for oxygen.

Review of the progress notes the week before and on the day of the 10/21/21 MDS revealed no notes that provided information about the resident's input on the MDS and CAA documentation.

Interview on 11/18/21 at 12:23 p.m. with MDS coordinator I revealed:
*Director of nursing services (DNS) B and social services designee (SSD) K also participated in completing the MDS and CAA documentation.
*They did not write separate progress notes related to the MDS documentation.
*She had no explanation for the absence of customary routines and preferences in the CAA worksheets.

Interview with DNS B would have inquired about the expectation for:
*Documenting supportive MDS assessment progress notes.
*Documenting further assessment in the CAAs of the resident's needs, routines, and preferences coded on the MDS.
*Using the CAA assessment to develop an

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individualized person-centered care plan.

On 11/18/21 at 9:00 a.m., administrator A and director of nursing services B were requested to meeting with the team anytime after 11:00 a.m. to discuss these and other findings, but they had not come to interview as of 11/18/21 at 3:00 p.m. when administrator A requested the team leave the building without finishing the survey and having an exit interview.

Review of the "RAI [resident assessment instrument] Version 3.0 Manual" dated October 2019 revealed the comprehensive assessment process revealed:
*The MDS is the "starting point" for collection of basic physical, functional, and psychosocial information about a resident, and "provides a foundation for a more thorough assessment and development of an individualized care plan."
*The CAA process provides a "framework" and a "link between the MDS and care planning" for:
-Review of triggered areas.
-Clarification of the resident's needs and related causes.
-"Additional assessment of potential issues, including related risk factors."
-Giving the team additional information to develop a "comprehensive plan of care."

2. Interview on 11/16/21 at 9:14 a.m. with resident 27 revealed he had needs and concerns related to:
*Getting a haircut. His friend who cuts his hair is away and he had not been offered a haircut here.
*Returning home to where he lived. No one had talked with him about going somewhere else.
*The recent insertion of a catheter and not wanting to have it permanently.

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Observation of resident 27 during the interview revealed:
*He was able to reposition himself to sitting on the edge of the bed.
*His hair was long and standing up on end after lying in bed.

Review of the 10/22/21 admission MDS assessment in the EMR for resident 27 revealed he:
*Entered the facility on 10/14/21.
*Had no difficulties with cognitive function or communication
*Had minimal difficulty hearing with the use of a hearing aid.
*Had little energy or was tired nearly every day and little interest or pleasure more than half of the days for the 14 day assessment timeframe.
*Had not walked during the 7 day assessment timeframe and needed staff weight-bearing support to do all other ADLs.
*Reported that it was very important for him to:
-Choose what to wear and his bedtime.
-Take care of his personal belongings and have a place to lock his things to keep them safe.
-Have snacks between meals.
-Have family involved in discussions about her care and use the phone in private.
-Read, keep up on news, do favorite activities, and participate in religious services.
*Participated in the admission MDS.
*Expected to be discharged and wanted to be asked about returning to the community on all assessments.

Review of the CAA worksheets completed with the 10/22/21 admission MDS revealed none of them included the resident's and his family's input

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regarding each care area, the resident's desire to return home, nor what he had reported as very important customary routines and activities.
*The ADL CAA did not note an evaluation of the problems for each ADL nor address goals regarding:
-Dressing and his preference for obtaining what he wants to wear.
-Toileting and transfer and goals for self-sufficiency related to his desire to discharge.
-Eating and his preference to have snacks between meals.
*The nutritional status CAA also did not address having his preference for snack between meals.
*The indwelling catheter CAA did not address his desire to have it removed.
*The activities CAA had "group activities" checked as his preference prior to admission but solitary activities, inside the home, or self-directed were not checked. No issues that reduced his activity participation were checked.
*The activities, psychosocial well-being, and return to community CAAs had the same note on each of them that addressed:
-His desire to stay in his room, napping and watching television, "not much different than home."
-Noncompliance with wearing a supportive boot when walking and not bearing weight on his foot when the boot is not on.
-A lifestyle of being "unhappy and grumpy" according to a conversation with his daughter.
-The desire to discharge without local support since his daughter lived out of state.
*The psychosocial well-being CAA did not address any relationship problems or customary lifestyle items relevant to the resident.

3. Interview on 11/15/21 at 4:24 p.m. with

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resident 37 revealed he:
*Waited "pretty consistently" for pain medication when his pain level was at a rating of 7 or 8 out of a 10 point scale.
*Developed an "open sore" on his heel that he did not know he had. A nursing assistant "discovered it." The staff are "supposed to" check his skin but, "I don't think they are."

Review of the 7/6/21 annual MDS assessment in the EMR for resident 37 revealed he:
*Had no difficulties with cognitive function or communication.
*Felt tired nearly every day during the 14 day assessment timeframe.
*Had not walked during the 7 day assessment timeframe, needed supervision of one staff for moving about in bed, and needed staff physical support to do all other ADLs.
*Reported pain occasionally "over the last 5 days" with a rating of 8.
*Was coded as not at risk for developing pressure ulcers and had no current pressure, venous, or arterial ulcers.

Review of the Pain CAA worksheet completed on 7/9/21 for resident 37 revealed:
*The resident "doesn't want routine pain medications, prefers to ask for PRN [as needed.]"
*The documentation does not address any of the following factors:
-Characteristics of the pain, where it is located, and what makes it better or worse.
-Frequency and intensity of the pain.
-Pain effect on his ability to function.
-Associated signs or symptoms of the pain.
-Effectiveness of the pain medication once given.

Review of the Pressure Ulcer/Injury CAA

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worksheet completed on 7/9/21 for resident 37 revealed:
*This condition triggered "due to assist needed with bed mobility."
*Extrinsic risk factors had just "pressure" and "special mattress."
*Other factors that were not automatically selected based on the coding of the MDS were not checked.
*There was no note to evaluate the effectiveness of supervision with bed mobility to prevent ulcers.

Review of the weekly skin and wound evaluations for resident 37 prior to the 7/6/21 MDS revealed:
*On 7/1/21, a pressure deep tissue injury was noted on his right heel that was acquired on 6/21/21 and measured 0.3 centimeters (cm) by 0.4 cm by 0.6 cm described as a hematoma.
*On 7/6/21, a venous ulcer was noted to his right heel that was acquired on 6/21/21 and measured 2.0 cm by 1.8 cm by 1.5 cm with the wound bed noted as a hematoma with the surface 100% (percent) intact and no drainage.
*On 7/15/21, the venous ulcer on his right heel was marked as resolved.
4. Review of resident 22's comprehensive assessment dated 10/12/18 revealed:
*Functional loss of ADLs (activities of daily living) in relationship to cognitive loss.
*Resident 22 was performing own ADLs with encouragement from staff.
*Care plan did not address any potential for decrease or loss of performing ADLs due to cognitive loss.
*Restorative nursing program and/or segmentation program to help with cognitive loss.
*Care plan dated 10/1/21 stated resident 22 is low risk for falls related to right knee pain and shuffling gait.

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F 636	Continued From page 68 *Care plan does not address assistance with ambulation and or assistive devices needed for mobility. 5. Review of resident 12's comprehensive assessment dated 6/2/21 revealed: *Vision field deficit was triggered. *Care plan does not address any problems with vision. *No interventions for visual aid. *Urinary incontinence was triggered. *Care plan does not address any incontinence or bladder program. *Falls potential was triggered. *Resident had a fall on 8/31/21. *Care plan dated 8/31/21 addressed risk for falls due to impaired mobility.	F 636		
F 656 SS=F	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656	1. All residents have the potential to be affected. Resident 15, 17 and 29 have had their care plan reviewed and updated as appropriate. Resident 12, 27, 28 and 37 have discharged. 2. The Divisional MDS Coordinator will provide developing a comprehensive care plan training to the IDT team prior to 12/22/21. 3. The DNS or designee will audit 4 random care plans weekly times four weeks and monthly times two months to ensure they are comprehensive to meet the residents needs/preferences. The DNS or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits. Addendum: Included in the education was gathering resident preferences and routines through interview of the resident/responsible party.	12/22/21

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F 656	Continued From page 69 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility did not develop comprehensive person-centered care plans for 7 of 15 sampled residents (12, 15, 17, 27, 28, 29, and 37) whose care plans were reviewed. Findings include: 1. Interview on 11/16/21 at 8:31 a.m. with resident 29 revealed she had concerns about eating in her room, use of oxygen, bathing frequency, grooming of her nails and hair, and not feeling well enough to do activities. Observation of resident 29 during the interview revealed she:	F 656		

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*Grimaced a few times and held her stomach area as she explained it was bothering her.
*Was using an oxygen concentrator.
*Had unkempt hair that was not brushed, frizzy, and standing up on end.
*Had long fingernails with dark colored residue under the tips.
*Had a basket of activity supplies, including coloring pages, next to the recliner in her room.

Review of the 10/21/21 admission minimum data set (MDS) assessment in the electronic medical record (EMR) for resident 29 revealed she:
*Needed physical help transferring between surfaces and moving about with her walker and wheelchair.
*Reported it was very important for her to choose what to wear, her bedtime, and type of bath; take care of and keep personal belongings safe, have snacks, do things alone and with groups of people.
(Refer also to F636, finding 1.)

Review of the resident 29's comprehensive care plan focuses and interventions revealed they did not address her concerns and preferences:
*Three separate focuses, initiated 10/21/21, included the intervention of oxygen use, but did not address:
-Her fear of going without her concentrator and the availability of using an oxygen tank.
-Her dependence on staff to assist with safely transferring due to the oxygen tubing.
*Activity involvement of "little to no" due to "anxiety, prefer to stay in room and rest," initiated on 10/28/21, had no interventions for:
-Support of in-room activities and keeping her activity supplies safe.
-Oxygen use while attending activities.

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*"Establish baseline plan of care," initiated 10/15/21, addressed:
-Bathing "weekly" in "whirlpool" without specifying if that bathing type was her choice.
-Bed mobility but did not specify her choice for bedtime.
-Dressing with no intervention to let her choose what she wanted to wear.
-Grooming without addressing how nail and hair care were to be provided.
-Meals in "dining room" without offering her a choice to eat in her room as she desired nor how she would access snacks between meals.

Review of task documentation for bathing revealed in the 30 days before 11/17/21, the only date she had received a bath was 10/29/21.

Review of the treatment administration record for November 2021 revealed nail care was documented as completed by registered nurse (RN) F on 11/8 and 11/15, but the condition of the resident's nails when observed on 11/16 noted above did not appear to be groomed.

Interview on 11/18/21 at 12:23 p.m. with MDS coordinator/RN I revealed:
*She had not thought about revising or replacing the "baseline plan of care" with a focus for activities of daily living (ADL) care needs.
*She provided no explanation for missing the person-centered information on resident 29's care plan.

Interview with director of nursing services (DNS) B would have inquired about:
*Development of individualized person-centered care plans.
*Updating the baseline care plan in accordance

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with the completed comprehensive admssion assesssment.
*Specific needs and concerns related to the sampled residents.

On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and DNS B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.

Review of the provider's policy titled, "Baseline Plan of Care," revealed:
*It is developed within 48 hours of admission.
*It includes information "sufficient to promote safe delivery of care."
*A progress note documents giving a copy of the baseline care plan to the "resident/representative."

Review of the "RAI [resident assessment instrument] Version 3.0 Manual" dated October 2019 revealed:
*"Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan."
*The care plan should be "revised on an ongoing basis to reflect changes in the resident and the care the resident is receiving."

2. Interview on 11/16/21 at 9:14 a.m. with resident 27 revealed he wanted to return home, did not want the catheter that was inserted before admission, preferred to stay in his room watching television, and needed a haircut, and was angry about a missing a pair of brand new jeans.

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Observation of resident 27 during the interview revealed he had a catheter in place, he had his television on, and his hair was long and standing up on end.

Review of the 10/22/21 admission MDS assessment in the EMR for resident 27 revealed:
*He expected to be discharged and wanted to be asked about returning to the community during each assessment.
*It was very important for him to do his favorite activities including reading and keeping up on the news, choose what to wear, and keep his personal belongings safe.
(Refer also to F636, finding 2.)

Review of the resident 27's care plan focuses and interventions revealed they did not address his concerns and preferences:
*Return to community, initiated on 10/26/21, indicated that topic should "be asked only on comprehensive assessments."
*Indwelling catheter, initiated 10/26/21, did not include a plan to address the resident's discontent with placement of the catheter.
*Satisfaction with activities, initiated on 10/28/21, did not address his in-room interests but directed staff to "Remind the resident that the resident may leave activities at any time, and is not required to stay for entire activity."
*Self-care performance deficit, initiated on 10/26/21, addressed:
-Assisting the resident to "choose simple comfortable clothing" but does not specify what a plan to keep his belongings safe.
-The resident's ability to comb his own hair, but it does not specify how his hair will be groomed.

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3. Interview on 11/15/21 at 4:24 p.m. with resident 37 revealed he:
*Waited "pretty consistently" for pain medication when his pain level was at a rating of 7 or 8 out of a 10 point scale.
*Developed an "open sore" on his heel that he did not know he had. A nursing assistant "discovered it." The staff are "supposed to" check his skin but, "I don't think they are."

Review of the 7/6/21 annual MDS assessment in the EMR for resident 37 revealed he reported pain occasionally "over the last 5 days" with a rating of 8, and was at risk for developing ulcers. (Refer also to F636, finding 3.)

Review of the resident 37's care plan focuses and interventions revealed the following focuses and interventions had not been modified based on the 7/6/21 comprehensive assessment:
*Pain stated, "I don't want any routine pain med at this time," initiated on 2/18/20 and revised 4/8/21, with an intervention for staff to "provide pain medication....and re-evaluate effectiveness within 60 minutes," initiated on 5/19/21.
*Two focuses addressed the risk for skin problems:
-History of venous stasis ulcers on his legs and feet, initiated on 9/18/17 and revised on 10/28/21 with an addition on 10/5/21, "I have a venous ulcer on my lateral aspect of R) [right] foot" and an intervention to provide snacks and "extra one oz [ounce] protein with meals" to help with healing, initiated on 12/25/15 and revised on 8/8/17.
-Peripheral Vascular Disease (PVD), initiated on 2/18/20 and revised on 4/8/21, without specifying how to "monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of skin

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problems, "initiated 11/25/15 and revised on 8/8/17.
*Hygiene/ADL's/Skin stated the resident "prefer this type of bath shower" and at "various days, times," initiated on 1/9/17. An intervention initiated on 11/16/15 and revised on 8/8/17 address staff cleaning and trimming nails his nails after baths, but do not specify monitoring of skin condition.
4. Review of resident 15's 9/10/21 care plan with a focus area for hospice revealed the interventions did not specify what the hospice certified nursing assistant (CNA) would have provided when he/she visited four to five times a week.

5. Review of resident 28's last revised on 10/28/21 care plan revealed no focus area, goals, or interventions for his left heel pressure ulcer blister.

Interview on 11/18/21 at 12:33 p.m. MDS coordinator/RN I revealed she had not added his pressure injury to his left heel. She tried to keep them as updated as possible but stated it was not possible to keep them all current all the time.
6. Observation on 11/16/21 at 8:52 a.m. in resident 17's room revealed the October 2021 activities calendar was posted on her wall. The November 2021 calendar was not posted.

At 9:25 a.m., resident 17 was observed sitting in her wheelchair in the area by the second-floor nursing station. The resident was idle but responded to the surveyor's greeting.

Review of resident 17's medical record revealed:
*On her 6/25/21 admission MDS assessment:
-Her interview for activity preferences indicated all areas of activity involvement were of importance

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F 656	Continued From page 76 to her. -She rated keeping up with the news as very important to her. *Her 6/29/21 admission activity care area assessment (CAA) was completed by social services designee K and indicated that the resident's activities functional status would be addressed in her care plan. *Her 6/28/21 care plan upon admission had no activity care plan. *Her updated care plan, revised on 11/15/21 had no activity care plan. 7. Review of resident 12's 5/24/21 care plan revealed she: *Had been admitted with a diagnosis of Guillan Barre upon admission on 5/24/21. -Autoimmune condition which attacks nerves. *Used a wheelchair for mobility. *Had not been triggered for a fall risk due to neurological disease. *Had fallen on 8/31/21. *Was an insulin dependent diabetic. *There was no focus or interventions for hypoglycemia associated with insulin administration. *There was no focus on resident activity likes or dislikes.	F 656		
F 658 SS=F	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, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 658	See next page	

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F 658	Continued From page 77 and manufacturer's recommendation review, the provider failed to ensure professional standards of care had been followed for six of six sampled residents (12,15, 28, 29, 32, and 37) as evidenced by: *Lack of documentation on medication administration record (MAR) and treatment administration record TAR for six of fifteen sampled residents (12, 15, 28, 29, 32, and 37). *Lack of documentation for one of one sampled residents (28) regarding their pressure ulcers and wounds. *Administration of insulin for one of one sampled resident (12) had been given at the incorrect time. *Lack of complete and accurate documentation by staff for resident 32's wound pump. Findings include: 1. Review of resident 15's November 2021 TAR revealed missed documentation for the following: *Full set of vital signs every Wednesday. No documentation for 11/3/21 and 11/10/21. *Fingernail and toenail care every Wednesday. No documentation for 11/3/21. *Weekly skin audit on Wednesday. No documentation for 11/3/21. *Hydromorphone 4 milligram (mg) four times a day for pain. No documentation for the 6:00 a.m. dose on 11/4/21 and 11/5/21. 2. Review of resident 28's October 2021 TAR revealed missed documentation for the following: *Micafungin sodium solution 100 mg intravenously (IV) one time a day. No documentation it has been administered on 10/24/21, 10/26/21, and 10/27/21. *Weekly skin audit every Friday and weight twice a week. No documentation for his 10/1/21 skin audit and no weight recorded on 10/1/21/ and	F 658	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The DNS or designee will educate all licensed nursing staff on accurate and timely documentation, following provider orders, proper administration of insulin and timing of insulin by 12/22/21. All licensed nursing staff not in attendance will be educated prior to their next working shift by the DNS or de-signee. 3. The DNS or designee will audit a random sample of eight residents (four from each floor) medication and treatment administration for accurate and timely delivery of medications and treatments weekly times four weeks and monthly times two months. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

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10/5/21.
*Documentation for a left heel blister present on admission 10/14/21 had not been documented on until 11/11/21. Refer to F686, finding 2)

3. Review of resident 32's interdisciplinary progress notes revealed:
*On 10/27/21 at 12:45 p.m. "Wound vac intact to left hip."
*On 10/28/21 at 8:30 a.m. "Noted wound vac container empty, no cord, no lights on, pump not running. Spoke to resident who states all wound pump supplies are in white bag. Cord for wound vac found in white bag et [and] plugged. Vac starts after approximately 2 minutes of being plugged in."

Review of resident 32's November 2021 TAR revealed missed documentation that included.
*Ceftriaxone [antibiotic] 2 grams IV one time a day. No documentation it had been administered on 11/3/21, 11/6/21, 11/8/21, and 11/10/21.
*Fingernail and toenail care, weekly skin audits, and weekly weights on Wednesdays. No documentation for those on 11/3/21 and 11/10/21.
*"Flush PICC [peripherally inserted central catheter] with 10 cc [cubic centimeter] normal saline before IV antibiotic and after complete. Two times a day for flush." No documentation it had been flushed for the 10:00 p.m. time on 11/1/21, 11/5/21, 11/11/21, and 11/14/21.
*Vancomycin [antibiotic] 759 mg IV two times a day at 10:00 a.m. and 10:00 p.m. No documentation the 10:00 p.m. dose had been given on 11/1/21, 11/5/21, 11/11/21, and 11/14/21.

4. Observation and interview on 11/15/21 at 8:25 a.m. with resident 12 revealed:
*She had been in the facility since May of 2021

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for physical and occupational therapy.
-She had been an insulin dependent diabetic for years.
*Received Novolog insulin scheduled for breakfast, lunch, and supper and sliding scale 3 times per day with meals depending on blood sugar.
-Novolog insulin is rapid acting insulin.
-Novolog insulin can start to work within 5-10 minutes of administration and peak is 1 hour after administration and keeps working for 2-4 hours.
*She would start shaking from her blood sugar being low.

Interview on 11/15/21 at 1:30 p.m. with resident 12's husband revealed:
*His wife was having issues with low blood sugars.
*Nurses would give her insulin at 8:30 a.m. and then she did not eat until 10:00 a.m.
*She had to see her endocrinologist to get an order to administer her Novolog insulin 15 minutes before meals.
*She had her blood sugar checked four times per day.
*Insulin was scheduled for 9:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m.

Interview on 11/16/21 at 8:20 a.m. with resident 12 regarding her insulin administration and interaction with nurses revealed:
*She stated that she had to argue with nursing staff to get her blood sugar and insulin given at the right time.
*She had been experiencing shaking when her insulin was given at 8:30 a.m., 12:30 p.m. and 4:30 p.m.
*Mealtimes are:
-7:00 a.m. continental breakfast (juice and a

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muffin)
-10:00 a.m. breakfast
-1:00 p.m. lunch
-5:00 p.m. supper
-8:00 p.m. evening snack
*She spoke with nursing about her shaking how she should not be given her insulin 1 hour before mealtimes.
*She stated staff were rude and upset with her when she refused to let them administer insulin too early.
*Staff would make remarks about her snacking and her blood sugar being elevated.

Interview on 11/16/21 at 8:27 a.m. with registered nurse (RN) H revealed:
*She used the TAR scheduled times to check blood sugar and administer sliding scale insulin.
*She checked resident's blood sugars then would administer insulin.
*She tried to give insulin within half hour of meal.
*She would reference the provider's insulin policy for administration of certain types of insulin.

Telephone interview on 11/17/21 at 12:25 p.m. with certified nurse practitioner N revealed:
*She had seen resident 12 on 10/21/21 regarding her insulin dosage.
*She had increased her Novolog insulin and instructed insulin to administered 15 minutes before meals.
*She requested for the provider to fax resident 12's blood sugars for the next two weeks after the insulin dose had been increased.
*She had not received any information since resident's clinic visit on 10/21/21.

Record review of resident 12's insulin administration times revealed:

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*October 2021 out of 164 administrations 89 times the insulin was administered at the incorrect time.
*November 1-18 2021 out of 89 administrations 46 times the insulin was administered at the incorrect time.

Policy review of provider's September 2014 Insulin Administration policy revealed rapid acting insulin onset 10-15 minutes of administration, peak half hour to three hours and duration is three to six hours.
5. Interview on 11/16/21 at 8:31 a.m. with resident 29 revealed she had concerns about bathing frequency and grooming of her nails and hair.

Observation of resident 29 during the interview revealed she had unkempt hair that was not brushed, frizzy, and standing up on end, and she had long fingernails with dark colored residue under the tips.

Review of task documentation for bathing revealed between 10/18/21 and 11/17/21, the only date she had received a bath was 10/29/21.

Review of the treatment administration record for November 2021 revealed nail care was documented as completed by registered nurse (RN) F on 11/8 and 11/15, but the condition of the resident's nails when observed on 11/16 noted above did not appear to be groomed.

6. Interview on 11/15/21 at 4:24 p.m. with resident 37 revealed he developed an "open sore" on his heel that he did not know he had.
A nursing assistant "discovered it." The staff are "supposed to" check his skin but, "I don't think they are."

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Review of the weekly skin and wound evaluations revealed two evaluations during the assessment window for the 7/6/21 minimum data set (MDS) assessment noted a wound that should have been coded on the MDS as a pressure ulcer and/or a venous ulcer.
(Refer also to F636, finding 3.)

Review of treatment administration records revealed a weekly skin audit was to be documented every Tuesday with a plus (+) sign denoting a new skin impairment and a minus (-) for no new impairment.
*In August 2021, every Tuesday had - except on 8/17/21 the field was blank, the skin audit was not done.
*In September 2021, every Tuesday's fields were blank.
*In October 2021, the timing for the skin audit changed from 11 am to "D 6-", and the coding changed to Yes and No instead of + and - signs.
-10/5 was marked as NA.
-10/12 was marked with a +.
-10/19 was marked as NO.
-10/26 was left blank.
*In November 2021,
-11/2 was marked as X.
-11/9 and 11/16 were marked a n.
(Refer also to F684, finding 2.)

Interview with director of nursing services (DNS) B would have inquired about the systems for :
*Monitoring missing or inaccurate documentation on the MAR and TAR.
*Conducting and documenting skin assessments.
*Monitoring the accuracy of insulin administration.

On 11/18/21 at 9:00 a.m. the survey team had

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F 658	Continued From page 83 requested executive director (ED) A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 658		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident	F 660	1. All residents have the potential to be affected. Resident 27 has discharged from the facility. 2. The DNS or designee will review the discharge planning process with the IDT team to ensure an appropriate discharge plan is established for each resident by 12/22/21. 3. The DNS or designee will audit a random sample of 4 residents weekly times four weeks and monthly time two months to ensure an appropriate discharge plan is in place and documented appropriately. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. Addendum: The IDT was educated to update the care plan with discharge plan preferences. TY/1/4/22.	12/22/21

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F 660	Continued From page 84 representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the	F 660		

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evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to assist with discharge planning for one of one interviewed resident (27) who stated his desire to return to his home. Findings include:

1. Interview on 11/16/21 at 9:14 a.m. with resident 27 revealed he wanted to return home.

Review of the 10/22/21 admission minimum data set (MDS) assessment in the electronic medical record (EMR) for resident 27 revealed he expected to be discharged and wanted to be asked about returning to the community during each assessment.
(Refer also to F636, finding 2.)

Review of resident 27's care plan focuses and interventions revealed "Return to community," initiated on 10/26/21, indicated that topic should "be asked only on comprehensive assessments."
(Refer also to F656, finding 2.)

Interview with director of nursing services (DNS) B would have inquired about the disconnect between the MDS and the care plan.

On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of

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F 660	Continued From page 86 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 660		
F 679 SS=F	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide an individualized activity program for ten of thirteen residents (5, 12, 13, 14, 17, 18, 19, 22, 24, and 29) that were interviewed. Findings include: 1. Observation on 11/16/21 at 8:52 a.m. in resident 17's room revealed the October 2021 activities calendar was still posted on her wall. The November 2021 calendar was not posted. At 9:25 a.m., resident 17 was observed sitting in her wheelchair in the area by the second-floor nursing station. The resident was idle, but she responded to surveyor's greeting. Review of resident 17's medical record revealed:	F 679	1. Unable to correct deficient practice noted during survey. Resident 5, 12, 13, 14, 17, 18, 19, 22, 24 and 29 activity program has been reviewed. All residents have the potential to be affected. 2. The ED or designee will educate all activity staff on providing an individualized activity program for each resident in the center by 12/22/21. All residents activity programs will be reviewed prior to 12/22/21 for individuality. 3. The ED or designee will audit a random sample of 4 residents for an individualized activity program weekly times four and monthly times two months. The ED or designee will bring the results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. Addendum: Activities will be offered through a variety of venues on evenings and weekends. TY 1/4/22.	12/22/21

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*On her 6/25/21 admission minimum data set (MDS) assessment:
-Her Brief Interview for Mental Status was scored at 10, indicating moderate cognitive impairment.
-Her interview for activity preferences indicated all areas of activity involvement were of importance to her.
-She rated keeping up with the news as very important to her.
*Her 6/29/21 admission activity care area assessment (CAA) was completed by social services designee K and indicated that the resident's activities functional status would be addressed in her care plan.
*Her 6/28/21 care plan upon admission had no activity care plan.
*Her updated care plan, revised on 11/15/21 had no activity care plan.
*There were no activities documented.
*There were no activity progress notes.

2. Interview on 11/16/21 at 1:30 p.m. with a group of residents during the resident council meeting, with local long term care ombudsman U revealed:
*They stated there used to be activities on the weekends, but not currently.
*The consensus of the group was that the days were too long on the weekends.
*They would also like to see more outings, especially during the holidays to see the holiday lights.
*One resident commented that the only difference between this place and prison is that this place does not have bars on the windows. The resident felt like he was imprisoned in this place.

Review of the 8/26/21 resident council minutes revealed the discussion on activities with Saturday and Sunday being too long of days with

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nothing to do. One resident had suggested to leave something out for the residents to do.
*There was no follow-up or resolution to the resident council's concern with activities.

Interview on 11/18/21 at 10:59 a.m. with activity assistant J revealed the provider currently had no activity director.

Interview on 11/18/21 at 2:22 p.m. with SSD K revealed she:
*Completed multiple parts of the MDS assessment, including the activity section.
*Completed the activity CAAs.
*Completed and updated resident care plans for her areas, including the activity care plan.
*Did not document a routine progress note for either activities or social services.
*Was not aware of any activity assessment, separate from the MDS assessment.
*Was not aware of the social service admission assessment until earlier this week.

Review of activity assistant J's spiral notebook that she used to keep track of activity programs and attendance revealed:
*The first page started 2/15/21 with Bingo at 2 p.m with 15 first names of residents.
*The final pages were dated 11/15/21 with "state surveyors" noted.
*There were 136 pages with dates noting the activity and first names of residents attending.
*Of the 274 days from 2/15/21 to 11/15/21, group activity programs were performed on 50% of the days.

Review of the provider's activity program policy, updated 7/2015 revealed:
*Activities include individual, small and large

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group, one-on-one, and independent activities to meet resident needs, abilities, and interests.
*For residents confined to, or who choose to remain in their room, the activity department provides and assists with in-room activities/projects/leisure pursuits in keeping with needs, abilities, and interests.
*Activities are offered at a variety of times to reflect resident's scheduling needs and preferences.
*Activities are posted on calendars within the center and in each resident's room.

3. Review of resident 12's care plan initiated on 5/24/21 revealed it did not identify any activities that she would like to participate in.

Observation of resident 12's room revealed the October 2021 activity calendar was hanging on the bathroom door.

4. Review of resident 22's care plan initated on 10/12/18 revealed:
*Preference about attending activites are of my choice and interest when I'm invited.
-I would like staff to anticipate my needs and address them.
*Activities I pursue independently include relaxing in my room, sitting in the living area, watching T.V. and chatting with staff or other resident's.
-I would like to have fun at activities.
*Activities staff provide monthly/year activity calendars and all staff assist me in planning attendance to activities of my choice of interest.

Observation of resident 22's room revealed the October 2021 activity calendar was hanging on the bathroom door.
5. Interview on 11/16/21 at 8:31 a.m. with resident

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F 679	Continued From page 90	F 679		

29 revealed she had concerns about:
*Attending activities because she had a "fear about running out of oxygen."
*Not feeling well enough to do her independent activities.

Observation of resident 29 during the interview revealed she:
*Grimaced a few times and held her stomach area as she explained it was bothering her.
*Was using an oxygen concentrator.
*Had a basket of activity supplies, including coloring pages, next to the recliner in her room.

Review of the 10/21/21 admission MDS assessment in the electronic medical record (EMR) for resident 29 revealed she reported it was very important for her:
*To take care of and keep her personal belongings safe.
*Do things alone and with groups of people.

Review of the CAA worksheets completed with the 10/21/21 admission MDS revealed the activities and psychosocial well-being CAAs did not address:
*Activity preferences and pursuits such as solitary activities, inside the home, or self-directed.
*Environmental and other issues that hindered activity participation, such as her need for oxygen.
*Strengths to build upon such as activities that put the resident at ease, gave a sense of satisfaction, and distinguished the resident before admission.
(Refer also to F636, finding 1.)

Review of the resident 29's comprehensive care plan focuses and interventions revealed:

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F 679	Continued From page 91 *Activity involvement of "little to no" due to "anxiety, prefer to stay in room and rest," initiated on 10/28/21, without interventions for: -Support of in-room activities and keeping her activity supplies safe. -Oxygen use while attending activities. (Refer also to F656, finding 1.) Review of the progress notes the week before and on the day of the 10/21/21 MDS and at the time of the care plan on 10/28/21 revealed there were no notes that provided information about the resident's input on the MDS/CAA documentation and her care plan. Interview on 11/18/21 at 12:23 p.m. with MDS coordinator I revealed she had no explanation for the absence of customary routines and preferences in the CAA worksheets and the care plan. Interview with executive director (ED) A would have inquired about: *The status of hiring a full-time activity director. *What efforts were being made to meet the activity needs of all residents. On 11/18/21 at 9:00 a.m. the survey team had requested ED A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 679		
F 684 SS=G	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 92 § 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, and record review, the provider failed to ensure residents received treatment and care in accordance with professional standards of practice to: *Ensure two of two residents (12 and 183) were free from abuse and neglect. Refer to F600. *Ensure a comprehensive skin care program had been followed to the prevent the development of skin ulcers for three of three residents (28, 37, and 182). Refer to F686 for residents 28 and 182. *Perform cardio-pulmonary resuscitation (CPR) for one of one resident (185) who had an advance directive requesting CPR. *Ensure one of one resident (20) was safe from accident hazards. Refer to F689. *Ensure one of one resident (182) who was receiving dialysis had consistent communication and collaboration of care. Refer to F698. *Ensure staff followed precautions to prevent the potential for spreading COVID 19 and other illnesses to all residents. Refer to F880. *Conduct routine COVID 19 testing for residents and staff to identify the presence of symptoms putting all residents at risk. Refer to F886. Findings include: 1. Interview on 11/15/21 at 4:24 p.m. with resident	F 684	1. All residents have the potential to be affected. Unable to correct deficient findings noted during survey. 2. Please refer to F600, F686, F689, F698, F880 and F886 for education details. 3. Please refer to F600, F686, F689, F698, F880 and F886 for audit details and QAPI follow-up.	12/22/21

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37 revealed he:
*Developed an "open sore" on his heel that he did not know he had.
*A nursing assistant "discovered it."
*The staff are "supposed to" check his skin but, "I don't think they are."
*Felt the meals provided limited options of food he wanted to eat. He had not had fried chicken or steak in a long time and asked for it to be added to the menu.

Review of the 7/6/21 annual minimum data set (MDS) assessment in the electronic medical record (EMR) for resident 37 revealed he:
*Had no difficulties with cognitive function or communication.
*Needed supervision of one staff for moving about in bed.
*Was coded as not at risk for developing pressure ulcers and had no current pressure, venous, or arterial ulcers.

Review of the weekly skin and wound evaluations revealed two evaluations during the assessment window for the 7/6/21 MDS noted a wound that should have been coded on the MDS as a pressure ulcer and/or a venous ulcer.
(Refer also to F636, finding 3.)

Review of the Pressure Ulcer/Injury care area assessment (CAA) worksheet completed on 7/9/21 revealed:
*This condition triggered "due to assist needed with bed mobility."
*Extrinsic risk factors had just "pressure" and "special mattress."
*Other factors that were not automatically selected based on the coding of the MDS were not checked.

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F 684	Continued From page 94 *There was no note to evaluate the effectiveness of supervision with bed mobility to prevent ulcers. (Refer also to F636, finding 3.) Review of the resident 37's current care plan revealed the following focuses and interventions: *History of venous stasis ulcers on his legs and feet, revised on 10/28/21 with an added statement dated 10/5/21, "I have a venous ulcer on my lateral aspect of R) [right] foot" and an intervention to provide snacks and "extra one oz [ounce] protein with meals" to help with healing, initiated on 12/25/15 and revised on 8/8/17. -Peripheral Vascular Disease (PVD), initiated on 2/18/20 and revised on 4/8/21, with and intervention that did not specify how to "monitor/document/report PRN (as needed) any s/sx (signs/symptoms) of skin problems," initiated 11/25/15 and revised on 8/8/17. *"Hygiene/ADL's/Skin," initiated on 1/9/17 with an intervention initiated on 11/16/15 and revised on 8/8/17 directing the cleaning and trimming of nails after baths, but does not address monitoring of skin condition. (Refer also to F656, finding 3.) Review of the quarterly MDS dated 10/5/21 revealed no changes in resident 37's cognitive or physical function, but one venous ulcer was coded as present. Review of weekly skin and wound evaluations revealed the progress of the venous ulcer noted on the care plan: *On 10/5/21, a new venous ulcer identified to the right side of his foot, measuring 7.3 centimeters (cm) by 4.1 cm by 2.3 cm with eschar (dark scab), a light amount of purulent (thick yellow) drainage that was faintly odorous. The physician	F 684		

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and dietitian were notified.
*On 10/21/01, the ulcer measured 8 cm by 2.7 cm by 4.1 cm with 10% (percent) of the wound bed with slough and 90% with eschar, and a moderate amount of purulent drainage.
*On 11/04/21, the ulcer measured 6.4 cm by 2.5 cm by 3.1 cm with 90% slough and 10% granulation (red connective tissue) in the wound bed and a moderate amount of purulent drainage with no odor. *On 11/17/21, the ulcer measured 6.6 cm, by 2.5 cm by 3 cm, with 50% granulation (red connective tissue) and 50% slough, serosanguineous (watery light red) drainage with no odor.

Review of a nursing progress note dated 10/6/21, related to the quarterly MDS dated 10/5/21, written by MDS coordinator I revealed:
*The resident needed supervision of one person to be reminded and assisted to reposition in bed.
*Had a vascular ulcer to his right foot.

Review of nutrition/dietary notes written by registered dietitian (RD) EE revealed:
*On 9/15/21, the resident "appears to not be motivated to eat or come out to meals," and told RD EE that "he does not want to and food is not good."
*On 10/6/21, The wound nurse says the new vascular ulcer to right side of the resident's foot is healable.
-The resident takes in 25-50% of regular food.
-RD EE recommended "magic cup" at dinner to provide 30 calories and 9 grams of protein.
*On 10/20/21, The resident was noted as no longer coming out of his room for meals and not eating them in his room. Weight loss is continuing.
-The resident refused "Cal Dense Med Pass" last

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month so it was discontinued.
-RD EE talked with resident but would not answer "why he has not been coming out (for meals) or why he has been eating less."
-The resident agreed with receiving chocolate i.e. cream shake with protein powder to give 600 calories and 18 grams of protein.
*On 11/16/21, RD EE asked resident about the ice cream shake and resident 37 said "he has not been getting it." Educated dietary staff about making and providing this every day at 3:00 p.m.

Review of treatment administration records revealed a weekly skin audit was to be documented every Tuesday with a plus (+) sign denoting a new skin impairment and a minus (-) for no new impairment.
*In June 2021, there were - signs on every Tuesday except 6/22/21 had a + sign.
*In July 2021, there were - on every Tuesday.
*In August 2021, every Tuesday had - except on 8/17/21 the field was blank, the skin audit was not done.
*In September 2021, every Tuesday's fields were blank.
*In October 2021, the timing for the skin audit changed from 11 am to "D 6-", and the coding changed to Yes and No instead of + and - signs.
-10/5 was marked as NA.
-10/12 was marked with a +.
-10/19 was marked as NO.
-10/26 was left blank.
*In November 2021,
-11/2 was marked as X.
-11/9 and 11/16 were marked a n.
3. Review of closed EMR and paper record for resident 185 revealed:
*He had passed away in the facility.
*He had a signed advance directive dated 5/28/21

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that stated he wanted limited treatment but still wanted to receive CPR.
*His documentation had not revealed any CPR had been performed.
*There was not another advance directive in his paper or electronic record.

Interview with the director of nursing services (DNS) B would have inquired about:
*The skin care system to monitor for the development of wounds.
*The system for auditing the accuracy of assessment and TAR documentation.
*The reason CPR was not performed on resident 185.

On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and DNS B to meet with the team any time after 11:00 a.m. to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.

F 686 SS=G — Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(ii) — F 686

§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

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F 686	Continued From page 98 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 two of two sampled residents (28 and 182) with facility acquired pressure ulcers received care, on-going assessments, and interventions to prevent wounds from worsening. Findings include: 1. Phone interview on 11/15/21 at 3:40 p.m. with resident 182's representative revealed: *Resident 182 had informed her that he had "many sores on his bottom." *The facility had never called to let her know that he had sores on his bottom. *He has also lost both of his lower legs due to sores. Review of resident 182's electronic medical record (EMR) revealed: *He had been admitted to the facility 12/8/20. *His diagnoses included: -Type II Diabetes. -Chronic Kidney disease. -Dependence on Renal Dialysis. -Chronic Lymphocytic Leukemia. *When he was admitted he had half of a right foot, and had been missing two toes on his left foot. -He had a wound vacuum (vac) applied to his right foot. *He had many various ulcers on his feet and legs throughout his stay at the facility. *On of the areas he developed at the facility was a skin tear to his right heel.	F 686	1. Unable to correct deficient practice noted during survey. Resident 28 and 182 are discharged. All residents have the potential to be affected. 2. The DNS or designee will educate all nursing staff on the skin policy by 12/22/21. All nursing staff not in attendance will be educated prior to their next working shift by the DNS or designee. 3. The DNS or designee will audit a random sample of 8 (four upstairs and four downstairs) residents to ensure turning/repositioning in place if indicated and ensure a weekly skin assessment is completed and proper interventions are in place to prevent skin breakdown weekly times six weeks and monthly time three months. The DNS or designee will bring the results of these audits will be taken to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. Addendum: Education included implementation/following of physician orders and wound vac utilization. TY 1/4/21	12/22/21

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*He ended up having a right below the knee amputation because of the right heel wound.

Review of resident 182's nursing progress notes revealed:
*He had an open spot to his right heel.
-This had been caused when the nurse removed the tape to his wound vac and it caused a skin tear.
*On 7/16/21, the physician had been notified:
-The area around the skin tear has developed a darkened bruise like area.
-There was serosanguinous (blood and liquid) drainage and the skin tear had a black scab.
-Nursing had asked to treat with anasept to the wound bed, hydrogel gauze, cover with oil emulsion, cover with Opti-foam and change three times per week with the wound vac changes.
*On 7/20/21 a wound consultant recommended using calcium alginate silver and negative pressure dressings.
*On 7/27/21 the order was changed to Betadine to the wound daily.
*7/30/21 through 8/10/21 he was in the hospital for sepsis.
*He had new orders on 8/17/21 to change dressing to right heel every day, apply calcium alginate silver and secure with kerlix.
*He was out of the facility from 9/14/21 to 9/23/21 due to having a left below knee amputation.
*On 9/30/21 he returned from an appointment with his orthopedic doctor with orders to:
-"...Paint right heel with Betadine twice daily, and cover with gauze."
*On 10/19/21 there was a note for him to continue to Betadine treatments.

Review of resident 182's wound assessments revealed:

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F 686	Continued From page 100 *The wound was noted to be an in-house acquired skin tear on 6/19/21. *The first wound assessment was not completed until 7/15/21. *On 7/15/21 the wound was: -12.3 centimeters squared (cm2) by (x) 4.6 centimeters (cm) x 3.7 cm. -Marked as healable. -being treated with generic wound cleanser and a compression wrap. *On 7/15/21 there was not documentation that the provider had been informed. *On 7/22/21 the wound was: -9.6 cm2 x 3.9 cm x 3.4 cm. -treatments and interventions the same as the 7/15/21 assessment. *On 7/29/21 the wound was: -11 cm2 x 3.6 cm x 4.2 cm -Marked as healing not achievable. *He was in the hospital until. 8/10/21. *On 8/10/21 the wound was: -26.1 cm2 x 6.9 cm x 5.2 cm. -Being cleaned with Iodine. -Had now been changed from a skin tear to a diabetic ulcer. *His next wound assessment was on 8/24/21 the wound was: -35.2 cm2 x 7.8 cm x 6.5 cm. -Being cleaned with generic wound cleanser and calcium alginate dressing. -Had now been changed from a diabetic ulcer to a venous ulcer. *On 8/31/21 the wound was: -32.7 cm2 x 9.2 cm x 5.7 cm. -Being cleaned with generic wound cleanser *On the 8/31/21 assessment there is a note that mentions: -The resident was being seen by infectious disease for wounds as well as wound care for	F 686		

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treatment plan. The current treatment was paint eschar with Betadine and cover with kerlix.
*On 9/8/21 the wound was:
-24.0 cm2 x 7.7 cm x 4.1 cm.
-Being treated with generic wound cleanser and calcium alginate dressing.
*The next wound assessment was on 10/1/21:
*The wound was now:
-61.3 cm2 x 10.1 cm x 7.8 cm.
-Marked as improving.
*Many of his wound documentation had not been marked for physician or power of attorney (POA) notification.

Review of resident 182's medication administration record (MAR) and treatment administration records (TAR) revealed:
*There had been many gaps with treatments related to resident 182's wounds.
*In august 2021 he had not received 5 out of 15 dressing changes for his right heel.
*He did not receive one out of three weekly skin audits.
*In September 2021:
-There had been no weekly skin audits documented on the MAR/TAR
-There had missing documentation for offloading of heels, wound vac therapy.
-Many gaps in applying skin protectant to buttocks.
*In October 2021:
-He missed three treatments to his right heel.
-Painting the area twice daily with Betadine had never been added to the MAR/TAR as the orthopedic doctor ordered.

Review of resident 182's dialysis communication forms revealed:
*On 10/4/21 the dialysis unit notified the long term

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F 686	Continued From page 102 care provider that: -Resident 182 had arrived at dialysis with a saturated dressing that was falling off. His heel had been actively bleeding as well. -The dialysis unit secured that dressing with a chux pad and Coban dressing so the nursing home staff could address the wound as ordered. *On 9/29/21 his right heel had been bleeding through his dressing upon arrive to the dialysis unit. *On 6/18/21 his would vac began beeping low battery and there was not a charge cord sent with the unit so it ended up shutting down. *The dialysis unit noted that he had a central line dressing that had not been changed in month, they had inquired about the status of this as it was not something that they were using. *On 1/1/21 the wound vac began beeping low battery a few hours after he arrive to the dialysis unit, the pump ended up shutting down because of the low battery. 2. Review of resident 28's skin and wound evaluations revealed: *On 11/11/21: -He had a blister on his right heel. -It has been listed as present on admission, which was 10/14/21. -It measured 2.1 centimeters (cm) long by 2.2 cm wide. -The dietician and therapist had been notified. -There was no indication the physician had been notified. -Interventions included: compression, cushion, foam mattress, incontinence management, mobility aide, moisture barrier, moisture control, repositioning device, and other. -It did not include any interventions to protect his heel.	F 686		

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F 686	Continued From page 103 *On 11/17/21: -He continued with a blister to his right heel. -It measured 2.5 cm long by 2.4 cm wide. -It was described as a serum filled blister. -The dressing was intact, cleansing solution was listed as soap and water, and generic wound cleanser. -Primary dressing was listed as other. -New interventions since the 11/11/21 assessment included customized shoe wear. -Progress was listed as deteriorating. -Nursing note: "Area is softer to the touch than last week. Area is intact with no redness or drainage noted." Review of resident 28's 10/14/21 admission - readmission nursing evaluation revealed it had not been completed. The only section with documentation was his vital signs. Those had all been from 10/8/21 when he had been transferred to the hospital. Review of resident 28's interdisciplinary (IDT) progress notes revealed on; *10/14/21 at 2:45 p.m. he had returned to the facility. *10/14/21 at 10:23 p.m. his great left and right toes were red. *10/15/21 at 1:24 p.m. his right heel was blistered and spongy. Skin prep and a gripper sock was applied. *10/18/21 at 11:03 a.m. he had a right heel had an intact blister. Skin prep was applied per treatment order. *10/28/21 at 1:42 p.m. he had a right heel blister. *11/8/21 at 10:27 a.m. "applying skin prep to L [left] heel -area dry, dark in color, no drainage, denies pain to touch." The assessment completed at 11:12 p.m. stated he had no open	F 686		

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skin areas.
*Review of the other IDT progress notes from 10/14/21 through 11/15/21 revealed twenty-nine out of the thirty-three days there had been no documentation regarding his right heel blister.

Observation and interview on 11/18/21 at 9:37 a.m. of resident 28's right heal with registered nurse (RN) D revealed a closed deflated blister with dry edges at the top. RN D applied skin prep to the blister. He did not wear any special shoes. He wore diabetic socks instead of the anti-embolism stockings he was to have worn. She was worried when the anti-embolism stockings were put on the blister would be opened.

Continued interview on 11/18/21 at 9:37 a.m. with RN D revealed she:
*Was the designated skin and wound nurse.
*Had been absent from work between 8/15/21 and 11/11/21.
*Found out about the blister and did the measurements on 11/11/21.
*In her absence director of nursing service (DNS) B was to have covered the completion and documentation of any skin concerns.

Review of resident 28's current care plan revealed it had not been updated with his right heel blister and any interventions that were in place.

Interview on 11/18/21 at 12:33 p.m. with minimum data set (MDS) coordinator I confirmed his right heel pressure injury had not been added to his care plan.

Review of the provider's May 2019 Skin Integrity

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policy revealed the following:
*The center had a systematic approach and monitoring process for evaluating and documenting skin integrity.
*Care was to have provided interventions to treat, heal, and prevent, if possible, and prevent the further development of skin ulcers/pressure ulcers/wounds."
*Skin evaluations were to have continued on a weekly basis.
*For skin impairment identified when admitted or after admission the following should have been completed including:
-Skin impairments would have included measurements of size, color, presence of odor, exudates, and presence of pain associated with the skin impairment in Nurse's Notes and on the Weekly Wound Evaluation.
-The physician would have been notified and orders for treatment received.
-Interventions would have been initiated.
-The registered dietitian would have been notified for a nutritional needs evaluation.
-The DNS and/or designee would have completed a comprehensive review of the resident's medical record to evaluate if the pressure ulcer was avoidable or unavoidable.
*All wounds were to have been evaluated weekly.

Interview with director of nursing services B would have inquired about implementation of the above policy.

On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and DNS B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without

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F 686	Continued From page 106 completing all survey tasks and interviews or conducting an in person exit interview.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure a safe and hazard free environment for one of one resident (20) who wandered. Findings include: 1. Random observations on 11/15/21 at 9:00 a.m., 11/16/21 at 2:00 p.m., and 11/18/21 at 10:00 a.m. revealed: *The second floor west hallway exit contained hazardous items including trowels, putty knife, caulk gun, paint buckets, sanding pads, and broom heads lying on the floor. *Resident 20, who resided on the same hallway, had elopement and wandering behaviors and wore a Wander Guard bracelet. Refer to F744. Interview on 11/18/21 at 11:30 a.m. with maintenance supervisor L revealed: *Trowels, putty knife, caulk gun, paint buckets, sanding pads, and broom heads were left by the contractor. *The contractor had not been working with that equipment for at least two weeks.	F 689	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The ED or designee will educate all staff on maintaining a hazard free environment by 12/22/21. All staff not in attendance will be educated prior to their next working shift by the ED or designee. 3. The ED or designee will audit the facility weekly times four weeks and monthly times two months to ensure the area remains free from hazard that could cause potential harm to residents. The ED or designee will take the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

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F 689	Continued From page 107 *He was unsure when work would resume. *He was not aware that materials needed to be secured from residents. Review of the provider's March 2018 Elopement/Wandering policy revealed: *Policy statement: The Center evaluates residents for wandering and/or exit seeking behavior and implements appropriate interventions. Interview executive director (ED) A and director of nursing services (DNS) B would have inquired if they felt the materials posed as a potential hazard and why the materials were still in the hallway. On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 689		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure	F 698	See next page.	

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F 698	Continued From page 108 communication and post dialysis assessments had been completed for one of one sampled residents (182) receiving hemodialysis treatments. Findings include: 1. Interview on 11/18/21 at 1:00 p.m. with licensed practical nurse (LPN) E revealed: *Resident 182 received hemodialysis at an outpatient dialysis unit three times per week. *They kept a binder of dialysis communication forms in a binder. -The forms were how they communicated about care and issues that may have been going on for resident 182. *They were supposed to fill out the form before he went to dialysis and when he returned from dialysis. Review of resident 182's dialysis communication forms from December 2020 through November 2021 revealed: *The forms contained areas for the provider to fill out a pre dialysis report. *The forms also had an area for the providers to fill out a post dialysis report. *From December 2020 through November 2020 there was: *Many missing post assessments, including missing access site assessments. *There was an area for documentation of resident's mentation upon return, those had not all been filled out. *There were missing dialysis transfer forms in their entirety. Review of the provider's dialysis contract with the outpatient dialysis clinic revealed: *The contract was effective 2/1/19. *The dialysis manager signed the contract	F 698	1. All residents receiving dialysis have the potential to be affected. Unable to correct deficient findings noted during survey. Resident 182 discharged. 2. The DNS or designee will educate all licensed nurses on dialysis communication and post dialysis assessments by 12/22/21. All licensed nurses not in attendance will be educated prior to their next working shift by the DNS or designee. 3. The DNS will audit all dialysis residents for dialysis communication and post dialysis assessments being completed weekly time four weeks and monthly times two months. The DNS or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	12/22/21

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F 698	Continued From page 109 5/13/19. *The representative from the provider signed the contract 5/17/20. *"Interchange of Information. The Company shall provide for the interchange of information useful or necessary for the care of the Residents, including a Registered Nurse or other appropriate Company employee as a contact person for the facility." *"Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Company and Dialysis Unit. Documentation shall include, but not be limited to, participation in care conferences, continual quality improvements, annual review of infection control of policies and procedures and the signatures of team members from both parties on a Short Term Care Plan (STCP) AND Long Term Care Plan (LTCP). Team members shall include the physician, nurse, social worker and dietitian from the Dialysis Unit and a representative from the Company. The Dialysis Unit shall keep the original the STCP and LTCP in the medical record of the Resident and the Company shall maintain a copy." On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m. to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 698		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40	F 740		

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F 740	Continued From page 110 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure two of two residents (4 and 22) who exhibited psychosocial needs received services from social services. Findings include: 1. Review of offsite selected resident 4's electronic medical record revealed: *She had dementia and Charles Bonnet Syndrome which resulted in visual hallucinations. *A social services note from 6/17/21 stated: -"Completed PHQ-9 [depression assessment] on resident for assessment, asked if she had thoughts of being better off dead or hurting herself. She said she's thought about both maybe 4 or 5 days. Asked if she had plans for harming herself, "oh no I'd never do anything." 2. During the resident council meeting on 11/16/21 at 1:30 p.m. resident 22 made comments regarding being uncomfortable with a male certified nursing assistant (CNA) and how he touched and took care of her. 3. Interview on 11/18/21 at 2:22 p.m. with social	F 740	1. All residents have the potential to be affected. Resident #22 care plan has been updated to reflect resident choice. Resident #4 has been and is currently receiving behavioral health services. 2. The ED or designee will educate the IDT team on ensuring residents who need/desire behavioral health services are utilizing it per their preference and that individual needs of the residents preference are being provided by 12/22/21. 3. The SSD will audit 4 random residents weekly times four weeks and monthly times two months to ensure their behavioral health needs are being met. The SSD or designee will bring the results of these audits to the monthly QAPI committee for further review or recommendation to continue or discontinue the audits. Addendum: SSD will be supported through monthly visits by SS consultant times three months and quarterly thereafter. Monthly and as needed visits will occur monthly times six months via zoom or in person by SSD from another sister facility. TY 1/4/21.	12/22/21

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F 740	Continued From page 111 services designee K regarding resident 4 and 22 revealed: *She had been in her current role since august 2021. *She had previously worked as a certified nursing assistant and certified medication aide. *The training in social services was "trial by fire;" there had not been a formal training process. *She had not informed anyone of resident 4's PHQ-9 assessments results because the resident stated she did not have any plans on harming herself. *Resident 22 had some history with a male about 20 years ago, that has resulted in some post traumatic stress for resident 22. *Surveyor asked SSD K if they had tried to ensure male CNAs had not worked with resident 22 so she does not relive any traumatic memories and she said no and that she had never thought to do that. 4. On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m. to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 740		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.	F 744	1. All residents with dementia/mental disability have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The DNS or designee will provide education to all staff regarding the care of residents with dementia/mental diasability by 12/22/21. 3. The DNS or designee will audit a random sample of four residents with dementia/mental disability soicial services related services are met weekly times four weeks and monthly times two months. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

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F 744	Continued From page 112 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to provide effective treatment and services for one of one sampled residents (22) behaviors related to dementia and moderate intellectual disability. Findings include: 1.Observation and interview on 11/18/21 at 11:00 a.m. with resident 22 revealed: *She was crying and upset. *Worried her sister would be mad at her because she did not tell where she was at. *Staff wheeled her away in her wheelchair without providing any reassurance. Review of resident 22's electronic medical record revealed: *She was admitted on 10/1/2018 with diagnoses of: - Unspecific dementia with behavioral disturbance - Moderate intellectual disability - Unspecified psychosis not due to a substance or known physiological condition -Major depressive disorder recurrent - Anxiety disorder -General anxiety disorder. *Resident 22 was receiving counseling services from an outside behavioral health service. *Progress notes from appointment on 6/17/21 revealed unconditional supportive therapy should be used to address tearfulness and confusion resident 22. Review of resident 22 care plan focus and interventions revealed: *Focus initiated on 10/1/18: "I tend to be a hypochondriac." "I often think I have chest pain." *Intervention nurse will complete evaluation to	F 744	Addendum: The psychological services provider will provide education to SSD and DNS or designee regarding her recommendation. The SSD, DNS or designee will in turn educate the staff on those recommendations and carrying them out. TY 1/4/21.	

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ensure my vitals are within normal limits and I am not experiencing true chest pain.
*Focus initiated on 5/19/21: "When I move from on area of the facility to another I often get confused and think I live in another building.
*Intervention: staff will assist resident 22 when she is confused. If needed let resident get into the elevator and push button for floor she thinks she lives on. Sometimes it helps to get out of the other side of the elevator.
*Focus initiated on 3/10/21:"I will often have delusions that I need to go somewhere or that she has things to do, but doesn't have items she needs."
*Intervention: resident 22 will remain calm, talk calmly and inform of days activities, remind her that we will let her know if she has an appointment. Try to redirect to watch TV or attend activities.
*Focus initiated on 1/11/19:"I cannot recognize a dangerous situation."
*Intervention: staff of one will assist resident 22 to recognize dangerous situations and move her to safety.

On 11/18/21 at 9:00 a.m., executive director (ED) A was requested to provide copies of social services progress notes related to resident 22. As of 1:46 p.m., no notes had been provided.

On 11/18/21 at 9:00 a.m. the survey team had requested ED A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.

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F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The DDCO will provide training to the DNS on ensuring a monthly drug regimen is completed by 12/22/21. 3. The DNS or designee will complete monthly times six months an audit to ensure all monthly medication reviews have been completed. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audit.	12/22/21

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F 756 Continued From page 115 — F 756

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the provider failed to ensure a monthly medication review was completed by a pharmacist on four of eight sampled residents (2, 12, 20, and 22).
Findings include:

Review of the following resident's monthly pharmacist medication review revealed:
*Resident 2 had seven out of ten months reviewed.
*Resident 12 had six out of ten months reviewed.
*Resident 20 had seven out of ten months reviewed.
*Resident 22 had seven out of ten months reviewed.

On 11/18/21 at 9:00 a.m., executive direcctor (ED) A was requested to provide copies of all monthly pharmacist medication reivews for these four residents. At 1:46 p.m., no missing reviews had been provided.

On 11/18/21 at 9:00 a.m. the survey team had requested ED A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.

F 760 SS=G Residents are Free of Significant Med Errors — F 760
CFR(s): 483.45(f)(2)

The facility must ensure that its-
§483.45(f)(2) Residents are free of any significant

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F 760	Continued From page 116 medication errors. 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 (12) had not experienced adverse effects from insulin administered at the incorrect time. Findings include: 1. Interview on 11/15/21 at 8:25 a.m. with resident 12 revealed: *She had been in the facility since May of 2021 for physical and occupational therapy. *She had been an insulin dependent diabetic for years. *She received Novolog 15 unit insulin subcutaneously scheduled for breakfast, lunch, and supper. *She also received sliding scale Novolog 3 times per day with meals depending on blood sugar. *She would start shaking from her blood sugar being low. *Staff did not recheck her blood sugar when she was shaking. *She would eat something to help with her shaking due to her low blood sugar. Interview on 11/15/21 at 1:30 p.m. with resident 12's husband revealed: *His wife was having issues with low blood sugars. *Nurses would give her insulin at 8:30 a.m. and then she did not eat until 10:00 a.m. *She had to see her endocrinologist to get an order to administer her Novolog insulin 15 minutes before meals. *She had her blood sugar checked four times per day. *Insulin was scheduled for 9:00 a.m., 12:00 p.m.,	F 760	1. All residents have the potential to be affected. Resident #12 insulin orders have been reviewed. 2. The DNS or designee will educate all licensed nursing staff on timely medication delivery and the insulin administration policy by 12/22/21. All licensed staff not in attendance will be educated prior to their next working shift by the DNS or designee. 3. The DNS or designee will audit a random sample of four residents for timely medication delivery and four licensed staff on their knowledge of the insulin administration policy weekly times four weeks and monthly times two months. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. Addendum: Education included following physician orders. TY 1/4/22.	12/22/21

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F 760	Continued From page 117	F 760		

5:00 p.m., and 9:00 p.m.

Interview on 11/16/21 at 8:20 a.m. with resident 12 regarding her insulin administration and interaction with nurses revealed:
*She had to argue with nursing staff to get her blood sugar and insulin given at the right time.
*She had been experiencing shaking when her insulin was given at 8:30 a.m., 12:30 p.m. and 4:30 p.m.
*Mealtimes were:
-7:00 a.m. continental breakfast (juice and a muffin)
-10:00 a.m. breakfast
-1:00 p.m. lunch
-5:00 p.m. supper
-8:00 p.m. evening snack
*She spoke with nursing about her shaking and how she should not be given her insulin 1 hour before mealtimes.
*She stated staff were rude and upset with her when she refused to let them administer insulin too early.
*Staff would make remarks about her snacking and her blood sugar being elevated.

Interview on 11/16/21 at 8:27 a.m. with registered nurse (RN) H revealed:
*She used the treatment administration record (TAR) scheduled times to check blood sugar and administer sliding scale insulin.
*She checked resident's blood sugars then would administer insulin.
*She tried to give insulin within half hour of meal.
*She would reference the provider's insulin policy for administration of certain types of insulin.

Telephone interview on 11/17/21 at 12:25 p.m. with certified nurse practitioner N revealed:

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F 760	Continued From page 118 *She had seen resident 12 on 10/21/21 regarding her insulin dosage. *She had increased her Novolog insulin and instructed insulin to be administered 15 minutes before meals. *She requested the provider to fax resident 12's blood sugars for the next two weeks after the insulin dose had been increased. *She had not received any information since resident's clinic visit on 10/21/21. Surveyor: 26632 Interview on 11/18/21 at 11:43 a.m. with licensed practical nurse E revealed: *Resident 12 did not want her insulin until her food was in front of her. *Resident 12 had gone to her physician and received an order not to administer her insulin sooner than fifteen minutes before eating. *Resident 12 received Novolog insulin. *She was not aware of the peak times for different types of insulin. *She stated "I need to know that?" Surveyor: 45383 Review of resident 12's medication administration record for insulin administration times revealed: *In October 2021, the insulin was administered at the incorrect time 89 out of 164 administration times. *On 11/1/21-11/18/21, the insulin was administered at the incorrect time 46 out of 89 administration times. Review of the provider's September 2014 insulin administration policy revealed rapid acting insulin onset 10-15 minutes of administration, peak half hour to three hours and duration is three to six hours.	F 760		

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F 760	Continued From page 119 On 11/18/21 at 9:00 a.m. the survey team had requested executive director (ED) A and director of nursing services B to meet with the team anytime after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m. when ED A came and requested the team to leave the building without finishing all survey tasks and interviews or conducting an in person exit interview.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The DNS or designee will educate all licensed staff on proper storage in medication refrigerators by 12/22/21. All licensed staff not in attendance will be educated prior to their next working shift by the DNS or designee. 3. The DNS or designee will audit all medication refrigerators weekly times four weeks and monthly times two months for proper storage. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review or recommendation to continue or discontinue the audits.	12/22/21

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F 761	Continued From page 120	F 761		

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the provider failed to ensure one of one medication refrigerator in the main level medication room did not have food and medications stored together.
Findings include:

1. Observation and interview on 11/18/21 at 2:05 p.m. with registered nurse (RN) D of the main floor medication room revealed:
*Both medications that included insulin pens, nebulizer medications, pre-filled influenza immunizations stored with food items of applesauce, pop, and juice.
*RN D confirmed the above finding.
*RN D stated the medications should not have been stored in that refrigerator. They medication refrigerator was located in the second floor medication room.
*RN D did not know who had brought those refrigerated medications and placed them in this refrigerator.
*RN D stated she had told them not to store them together.

A policy was requested from executive director A for medication storage on 11/18/21. ED A stated they did not have a policy.

On 11/18/21 at 9:00 a.m. the survey team had requested ED A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.

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F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.	F 801	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. ED has been in contact with a staffing agency in regards to a temporary CDM until the center is able to hire one full time with an approximate two week time frame for hire. 3. The ED or designee will ensure that the facility has a qualified dietary nutrition professional. The ED will report on the status of the qualified dietary nutrition professional at the monthly QAPI meet-ing for review to ensure that the center has a qualified dietary nutrition profes-sional in the center monthly times six months. Addendum: The open position has been advertised since 5/1/2021. The interim started 1/4/22. TY 1/4/22.	12/22/21

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F 801	Continued From page 122 (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview, the provider failed to designate a qualified person to serve as food and nutrition services supervisor. Findings include: 1. Interview on 11/15/21 at 8:00 a.m. with food	F 801		

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F 801	Continued From page 123 and nutrition services (FANS) cook FF revealed there was no one designated as the supervisor and that position was vacant. Interview on 11/16/21 at 10:25 am. with divisional director of clinical operations (DDCO) C revealed registered dietitian (RD) EE was providing increased oversight during the vacancy. Review of the nutrition/dietary notes in resident 37's record revealed documentation by RD EE every two weeks. Interview with executive director (ED) A regarding this vacancy did not occur during the survey. On 11/18/21 at 9:00 a.m., the survey team had requested ED A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 801		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced	F 804	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The ED or designee will educate all dietary staff that food be prepared by methods that conserve nutritive value, flavor and appearance and that food and drink is palatable, attractive and at a safe and appetizing temperature by 12/22/21. All dietary staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audit 3 meals weekly times four weeks and monthly times two months to ensure (cont)	12/22/21

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F 804	Continued From page 124 by: Based on observation, interview, and policy review, the facility failed to ensure food served to the residents was palatable and at a safe and appetizing temperature. Findings include: 1. Observation on 11/15/21 during the breakfast meal service revealed: *At 9:50 a.m., food and nutrition assistant (FANS) aide CC, was taking beverage glasses filled with various juices and milk off a wheeled cart and placing them on the dining room tables. This was before most of the residents had been seated at the tables. *At 10:02 a.m., requested FANS aide CC pour a glass of chocolate milk for temperature testing at the end of the meal service. *At 10:06 a.m., FANS cook FF, started setting up plates of food for delivery to residents. He poured milk on the bowls of cereal before handing the plates off to FANS aide CC. She placed an insulated plastic dome on the top of each plate and then put the plates on a wheeled delivery cart. *At 10:08 a.m., FANS aide GG was placing plastic lids on numerous filled beverage glasses that were setting on two shelves of a wheeled cart. Activity assistant (AA) J moved the covered filled beverage glasses from the cart to the delivery cart next to each plate that was to be delivered. *At 10:18 a.m., one delivery cart with covered plates and beverages left the dining room for resident rooms. FANS aide CC and AA J began filling another delivery cart. *At 10:24 a.m., AA J and registered nurse (RN) D commented that the cart was really "stacked." The cart had 3 shelves with 4 plates and beverage glasses crowded together on each	F 804	that meals are served in a nutritive, appealing and palatable manner. The ED or designee will take the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	

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F 804	Continued From page 125	F 804		

shelf.
*At 10:28 a.m., AA J and FANS aide CC left the dining room with the cart to deliver the meals to the resident rooms on the main floor.
*At 10:29 a.m., a glass of chocolate milk that had been setting on the beverage cart tested at 52 degrees by FANS cook FF, using the provider's digital thermometer. He said, "It's been out awhile."

Interview on 11/15/21 9:50 a.m. with resident 27 revealed the "food is terrible." After the breakfast meal on 11/15/21 at 10:45 a.m., the resident reported his rice krispies were soggy. He ate his breakfast in his room.

Interview on 11/16/21 at 8:26 a.m. revealed FANS aide CC starts setting up for breakfast at 9:35 a.m, first setting out silverware and cover ups, then ice water, then filled beverage glasses.

Observation on 11/18/21 at 10:03 a.m. revealed FANS cook FF poured milk onto cereal in bowls before the plates were delivered to the residents at dining room tables.

Review of the provider's policy for serving food, published July 2008, revealed no procedures regarding the timing for filling beverage glasses before meals or how to keep beverages and cereal palatable and with an acceptable temperature.

Interview with executive director (ED) A regarding these observations did not occur during the survey.

On 11/18/21 at 9:00 a.m., the survey team had requested ED A and director of nursing services

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F 804	Continued From page 126 (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person exit interview.	F 804		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, menu review, and policy review, the provider failed to ensure: *A substantial evening snack was provided between supper/dinner and breakfast. *Obtain resident group agreement for a lapse of over 16 hours.	F 809	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The ED or designee will educate all staff on providing or offering a substantial nourishing snack at bedtime and that there is no greater than a 16 hour gap between supper and breakfast by 12/22/21. All staff not in attendance will be educated by the ED or designee prior to their next working shift. 3. The ED or designee will audit the HS snack to ensure a substantial nourishing snack is provided and there is no greater time lapse than 16 hours between supper and breakfast three times weekly times four weeks and monthly times two months. Addendum: Breakfast is scheduled at 9:30 AM and Supper at 5:30 PM to ensure a lapse of no greater than 16 hours. The ED will review satisfaction with meal times quarterly at resident council.	12/22/21

F 809 Continued From page 127 F 809

Findings include:

1. On 11/15/21 at 8:20 a.m. a schedule of mealtimes was requested from executive director (ED) A during the survey entrance conference.

Review of the mealtimes schedule ED A provided listed mealtimes as:
*Early breakfast at 7:00 a.m.
*Breakfast at 10:15 a.m.
*Lunch at 1:00 p.m.
*Dinner at 5:30 p.m.
*Late snack at 8:00 p.m.

Observation of the mealtimes schedule posted in a frame on the dining room wall listed a variation from the list executive director A provided:
*7:00 a.m. in-room early breakfast.
*9:45 a.m. main breakfast.
*1:00 p.m. lunch.
*5:00 p.m. supper
*8:00 p.m. in-room late supper.

Both of the mealtime schedules have a lapse of 16.5 hours between breakfast and supper/dinner.

Review of the provider's 2021-2022 menu revealed:
*The in-room early breakfast, called the "5 a day meal breakfast," included fruit juice, banana, vanilla yogurt, muffin with butter and jelly, coffee and tea, and milk.
*The in-room late snack/supper was not included on the menu.

Observation on 11/16/21 at 7:30 a.m. revealed food and nutrition services (FANS) aide CC pushing a wheeled cart with in-room early breakfast items down the resident hallways on

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F 809	Continued From page 128 the main floor. Interview on 11/16/21 at 08:29 a.m. with FANS aide CC confirmed early breakfast included muffin and juice, coffee is provided, and sometimes a banana. Group interview on 11/16/21 at 1:30 p.m. with a group of residents and local long-term care (LTC) ombudsman U revealed the group felt the main breakfast at 10:00 a.m. was "too late." Interviews on 11/18/21 at the following time regarding the 8:00 p.m. in-room late supper revealed: *At 9:42 a.m. FANS cook FF said there was no written menu or list of food items for the late snack. The certified nursing assistants prepare and serve ice cream or sandwiches that are prepared from food "usually leftover from lunch" out of the "upstairs kitchen." *At 9:51 a.m. FANS cook Q stated, "It's a snack," not "supper" and only included a sandwich or ice cream. Review of the provider's July 2008 Scheduled Meal Hours for Five Meal a Day Plan policy revealed: *The mealtimes are "established by our facility for residents." "A schedule of mealtimes is posted in resident areas. Review of the provider's January 2019 admission agreement revealed at least three meals a day would be available with snacks between meals and at bedtime.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		

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F 812	Continued From page 129 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 and interview, the provider failed to ensure food was served to residents by two of two food service staff (GG and W) without cross-contamination of harmful substances or microorganisms during two of two meals observed. Findings include: 1. Observation on 11/15/21 during the breakfast meal service revealed food and nursing services (FANS) cook W touched contaminated surfaces and then continued serving food without washing his hands: *He touched the side of his face. *He leaned down with his arms in his sweatshirt sleeves onto the serving countertop. When he stood upright, he shifted his pants and sweatshirt.	F 812	1. All residents have the potential to be affected. Unable to correct deficient practice noted during survey. 2. The ED or designee will educate all dietary staff on hand washing and glove use by 12/22/21. All dietary staff not in attendance will be educated prior to their next working shift. 3. The ED or designee will audits proper hand hygiene and glove use on a random sample of four dietary staff weekly times four weeks and monthly times two months. The ED or designee will take the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	12/22/21

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F 812		F 812		

Continued From page 130
*He placed his hands in his pockets.
*He wiped off the griddle with a rag and then rinsed the rag in the sink.

Observation on 11/15/21 at 10:11 a.m. revealed FANS aide GG touched the inside of plastic lids with his bare hands before putting the lids on beverage glasses filled with various juices and milk.

Observation on 11/18/21 at 10:20 a.m. revealed FANS cook W touched his face mask and then picked up utensils wrapped in paper napkins and placed them on the delivery cart for room trays.

Interview on 11/15/21 at 7:45 a.m. with FANS cook FF revealed the facility currently does not have a certified dietary manager.

Interview on 11/15/21 at 8:30 a.m. with executive director A confirmed the dietary manager position was vacant.

Interview on 11/18/21 at 1:00 p.m. with FANS cook FF revealed and FANS cook Q have current SERV Safe certificates.

Interview with executive director (ED) A regarding these observations did not occur during the survey.

On 11/18/21 at 9:00 a.m., the survey team had requested ED A and director of nursing services (DNS) B to meet with the team any time after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m., when ED A came and requested the team to leave the building without completing all survey tasks and interviews or conducting an in person

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F 812	Continued From page 131 exit interview.	F 812		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being of all thirty-six residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews from 11/9/21 at 9:00 a.m. through 3:00 p.m., 11/11/21 at 9:30 a.m. through 10:00 am., 11/15/21 at 7:15 a.m. through 5:30 p.m., 11/16/21 from 7:30 a.m. through 6:00 p.m., and 11/18/21 from 8:00 a.m. through 3:45 p.m. revealed executive director (ED) A had not ensured safe management and overall well-being of all the residents who lived in the facility. ED A's and director of nursing services (DNS) B's job descriptions had been requested on 11/17/21 from ED A, and again on 11/18/21 at 9:00 a.m. The job descriptions had not been received by 11/22/21 at 12:05 p.m. when ED A stated all the policies that had been requested had already been provided or there was no policy. On 11/18/21 at 9:00 a.m. the survey team had	F 835	1. All residents have the potential to be affected. 2. The Divisional Director of Clinical Operations reviewed the ED job description with ED and DNS prior to 12/22/21. 3. The ED or designee will complete audits for F550, F553, F561, F565, F572, F578, F580, F585, F600, F625, F636, F656, F658, F660, F679, F684, F686, F689, F698, F740, F744, F756, F760, F761, F801, F804, F809, F812, F880, F885 and F886. The ED will take the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits. The DDCO will ensure these audits are completed weekly times four weeks and monthly times two months. There will be continue oversight and availability of the DDCO for the next quarter. Addendum: The DDCO will review ED performance during visits to the center. TY 1/4/21	12/22/21

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F 835	Continued From page 132 requested executive director (ED) A and director of nursing services B to meet with the team anytime after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m. when ED A came and requested the team to leave the building without finishing all survey tasks and interviews or conducting an in person exit interview. Refer to F550, F553, F561, F565, F572, F578, F580, F585, F600, F625, F636, F656, F658, F660, F679, F684, F686, F689, F698, F740, F744, F756, F760, F761, F801, F804, F809, F812, F880, F885, and F886.	F 835		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and	F 837	1. Unable to correct deficient practices noted during survey. All residents have the potential to be affected. 2. Job descriptions were reviewed with DDCO and ED by 12/22/2021. The DDCO will continue bi-weekly visits times two months and re-evaluate at that time for continued frequency of visits. 3. The ED or designee will complete audits regarding F550, F553, F561, F565, F572, F578, F580, F585, F600, F625, F636, F656, F658, F660, F679, F684, F686, F689, F698, F740, F744, F756, F760, F761, F801, F804, F809, F812, F880, F885 and F886. The ED or designee will take the results of these audits to the monthly QAPI committee for review and recommendation to continue or discontinue the audits. The governing board will be in attendance at the meeting to review these audits until substantial compliance is met. Addendum: Staff educated on policy changes routinely. Education on policies provided during orientation. Staff educated on location of policy manuals in the center. TY 1/4/22.	

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F 837	Continued From page 133 overall well-being for all thirty-six residents in the facility. Findings include: 1. During the survey on 11/9/21 at 9:00 a.m. through 3:00 p.m., 11/11/21 at 9:30 a.m. through 10:00 am., 11/15/21 at 7:15 a.m. through 5:30 p.m., 11/16/21 from 7:30 a.m. through 6:00 p.m. and 11/18/21 from 8:00 a.m. through 3:45 p.m., the provider had not operated in a manner to ensure residents received quality care. Executive director (ED) A had not been assisted with his duties to ensure he was able to effectively provide guidance to staff to be able to provide quality care. Refer to F550, F553, F561, F565, F572, F578, F580, F585, F600, F625, F636, F656, F658, F660, F679, F684, F686, F689, F698, F740, F744, F756, F760, F761, F801, F804, F809, F812, F835, F880, F885, and F886.	F 837		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880	See next page	

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reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

F 880

Directed Plan of Correction
Riverview Healthcare Center
F880, F885, F886
Corrective Action:

1. For the identification of lack of:
   *Appropriate wearing of PPE [Addressed in IJ]
   *Appropriate fit-testing for use of N95 masks [Addressed in IJ]
   *Quarantining residents who may have had contact with COVID-19 positive. [Addressed in IJ]
   *Appropriate cleaning and disinfection chemical contact times. [Addressed in IJ].
   *Appropriate cleaning of resident rooms to mitigate risk for spread of infection. [Addressed in IJ]
   *Appropriate notification of residents and resident families of COVID-19 outbreak.
   *Appropriate testing procedures of staff and residents during an outbreak [Addressed in IJ].
   *Appropriate technique during dressing change.

The administrator, DON, infection control nurse and/or designee in consultation with the medical director will review,

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corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
A. Based on observation, interview, policy review, and reference source review, the provider failed to implement proper infection control practices for the coronavirus (COVID-19) pandemic with the potential for exposing residents and staff to serious harm including death, by failing to ensure:
*Infection control practices were followed to prevent exposure and potential spread of COVID-19.
*All staff had been properly fitted for N95 masks to prevent the potential for COVID-19 exposure.
*All staff had been medically cleared to wear N95 masks.
*The health and safety of all staff and residents.

These failures had the potential to expose all residents, staff, and visiting essential personnel to COVID-19, a viral infection that could lead to serious harm or death.

NOTICE:
On 11/9/21 at 2:40 p.m. an Immediate Jeopardy was identified when the facility failed to ensure:
*Staff were wearing personal protective equipment (PPE) properly during a COVID-19 facility outbreak while providing direct care to residents.

F 880

revise, create as necessary policies and procedures for dressing change and ensure continuation of IJ removal plan.

All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by ED or designee by 12/22/21.

Identification of Others:

1. ALL residents and staff have the potential to be affected if staff do not adhere to identified areas.
Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by ED or designee by 12/22/21.

System Changes:

2. Root cause analysis conducted utilizing the fishbone diagram:
1. Unvaccinated dietary staff become Covid positive.
2. Center utilizing contract staff.
3. County positivity rates were high.
4. Missed opportunity for staff with hand hygiene.
5. Improper mask wearing.
6. Lack of disinfecting durable equipment between residents.
The above are the potential causes of Covid outbreak in the the center.

Administrator, DON, infection control nurse, medical director, and any others identified as necessary will ensure ALL facility

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F 880	Continued From page 136 *Staff had been fit-tested for N95 makes during a COVID-19 facility outbreak. *Failed to ensure one of one housekeeping staff had been aware of the proper disinfection process and chemical contact time while in COVID-19 outbreak status. *One of one housekeeping staff members cleaned resident rooms using practices to mitigate infection spread. *Quarantine residents who may have had contact with a resident who had tested positive for COVID-19. At the above time the executive director (ED) A and director of nursing services (DNS) B were asked for an immediate plan of correction (POC) to ensure all staff working in the facility received education and monitoring for nationally recognized infection control procedures. PLAN: On 11/10/21 at 1:40 p.m. the divisional director of clinical operations (DDCO) C, ED A, and DNS B, provided the surveyor with an email that included the final written removal plan. The written removal plan was approved by the long-term care advisor for the department of health on 11/10/21 at 1:50 p.m. The facility provided the following acceptable removal plan on 11/10/21: "1. Staff directly observed will be reeducated on proper mask wearing. Handwashing and glove use education will be provided to all staff. All staff will be re-educated on wearing face-shields during shifts. All staff will be re-educated on cleaning of equipment between resident use. This education completed on 11/9/21 by 11:59 p.m. All staff not educated will be educated prior to their	F 880	staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. The DDCO contacted the South Dakota Quality Improvement Organization (QIN) on **12/10/21** and a call was held on 12/14/21 with the DDCO, ED and DNS including 2 members of the QIO. A discussion was held regarding RCA and auditing. **Monitoring:** 1. Administrator, DON, infection control nurse, and/or designee will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective implementation and ongoing sustainment include at a minimum 2-3 times weekly for 4 weeks, administrator, DON, infection control nurse, and/or a designee making observations across all shifts to ensure compliance with: *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis.	

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next working shift."
"2. All housekeeping staff will be educated on the disinfecting process and chemical contact time by 7:30 AM on 11/10/21. All housekeeping staff not in attendance will be educated prior to their next working shift."
"3. Any residents or staff who test positive will be evaluated for close contacts who would need to be quarantined. Any close contacts for the positive resident were evaluated on 11/4/21 prior to 10 AM and no close contacts were identified."
"4. All staff required to wear N95 masks will be fit-tested and medically cleared to wear N95 masks. This will be completed by 3 PM on 11/10/21. All those requiring fit-testing not in attendance will be fit-tested prior to their next working shift."
"5. All nursing staff re-educated and competency done for proper PPE don/doffing by 11/9/21 at 11:59 PM. All nursing staff not in attendance will be educated prior to their next working shift."

The immediate jeopardy had been removed on 11/11/21 at 9:40 a.m. after verification that the provider had implemented their removal plan. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "F."

1. Observation and interview on 11/9/21 at 9:00 a.m. revealed:
*Surveyors entered through the facility's main entrance:
*There had been an unidentified staff member walking in the building without a face shield on.
*Housekeeping staff member S identified the staff member as dietary staff Q.

Entrance conference on 11/9/21 at 9:30 a.m. with ED A and DNS B revealed they:

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F 880	Continued From page 138 *Were currently in COVID-19 outbreak status. *Resident 184 had tested positive for COVID-19 after being transferred to the hospital. *They had expected staff to wear N95 masks and face shields while in outbreak. 2. Interview on 11/9/21 at 9:40 a.m. with DNS B revealed: *They were currently testing all residents in the facility because they had been unable to identify close contacts to resident 184. *They were testing residents and staff on Mondays and Thursdays. *No residents were being quarantined. 3. Observation on 11/9/21 at 9:45 a.m. of the facility's west second floor hallway revealed: *Licensed practical nurse (LPN) T had been coming out of resident 3's room. -Her N95 was down underneath her nose. *She had then walked into resident 182's room and the shared room of resident 21 and 14. -Her N95 mask was still down underneath her nose. *She had performed hand hygiene when she arrived back at her medication cart, but not in between resident 3, 182, and 21 and 14's room. 4. Observation on 11/9/21 at 9:47 a.m. revealed certified nursing assistant (CNA) R wearing an N95 mask that had visible gaps around her nose and sides of her mouth. 5. Observation on 11/9/21 at 9:48 a.m. of CNA O revealed she: *Came out of resident 3's room with her N95 underneath her chin, pushing a stand lift. -Did not disinfect the lift or sanitize her hands. *Then went into resident 182's room with soiled	F 880		

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hands and her N95 mask underneath her chin.
*Went from resident 182's room to resident 18 and 6's shared room.
-Had not sanitized her hands and her N95 mask was underneath her chin.

6. Observation and interview on 11/9/21 at 9:50 a.m. of housekeeping staff V cleaning resident 182's room revealed she:
*Had sprayed Virex on all surfaces in the bathroom.
*Believed the contact time for the disinfectant was five minutes.
*Wiped the surfaces off with her blue rag.
*Stated the blue rag she used in the bathroom, the red rag was used in the bedroom.
*Finished cleaning the bathroom and with the same soiled gloves she had been wearing to clean the bathroom.
*Began moving resident 182's breakfast juices, tv remote and other personal items.
*Had a red rag in one hand and a blue rag in the other hand.
-Touched his drinking glasses and remotes with the soiled gloves and blue rag.
*Had the same process when cleaning COVID-19 rooms, although sometimes they will use bleach.

Interview on 11/9/21 at 10:03 a.m. with CNA O revealed:
*Surveyor mentioned that she noticed her N95 was under her chin while caring for residents.
*She stated, "that's because I can't breathe with it on."
*Surveyor asked if she had been fit-tested for the N95 mask that she had been wearing, she "thought she had."

7. Observation on 11/9/21 at 10:05 a.m. of

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registered nurse (RN) F revealed she had not been wearing a face shield.

Interview on 11/9/21 at 10:30 a.m. with ED A and DNS B revealed:
*They were not short on PPE supplies or testing supplies.
*DNS B stated they were not sure where resident 184 had contracted COVID-19.
*Surveyors shared their infection control concerns and lack of hand hygiene being performed by staff members.

Further interview on 11/9/21 at 12:45 p.m. with DNS B revealed:
*They have a COVID-19 outbreak strategy action plan.
*They had not filled it out for the COVID-19 outbreak that began on 11/4/21.

Review of the provider's November 2020 COVID-19 Outbreak Strategy Action Plan form revealed:
*The Immediate actions that were to be put into place included:
-Transmission-based precautions implemented with door closed and appropriate signage.
-The shared bathroom would be closed and residents were to use separate bedside commodes.
-All recent transfers or discharges are notified of COVID-19 Center outbreak.
-"The Center-wide testing strategy has been implemented. (All staff and residents must be tested immediately upon receiving the first positive result, testing all the negative staff and residents should occur at a minimum of every 7 days thereafter until 14 days have passed with no new positive cases identified."

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-Consistent staff should be assigned to infected/symptomatic residents.
-Line listing would be initiated and updated.
-Infection Preventionist maintains mapping and trending of unit/room outbreak.
-"Patient cases placed on "alert/change of condition charting each shift and infection control care plan in place."
-"Increased active monitoring/screening to every 2 hours implemented for positive symptomatic resident and roommate."
-"Increased active monitoring/screening for all residents to every 4 hours during active outbreak."
-"The PPE capacity strategy has been reviewed."
-"Restrict communal activities."
-"Suspend activities on affected unit."
-"Restrict communal dining."
-"Restrict visitation per state and health department guidelines. (Except in cases of compassionate care/end of life visits.) Encourage virtual visitation."
-"The Center has reviewed and is in compliance with the Covid-19 Focused Survey for Nursing Homes."
*There were three other pages of the outbreak plan that went through the steps that should be implemented or looked at when an outbreak in the facility occurs.

Interview on 11/9/21 at 1:00 p.m. with RN G revealed she:
*Had not tested resident 184 for COVID-19.
*Agreed that the symptoms he had been experiencing were known COVID-19 symptoms.
*Stated that licensed nurses are supposed to complete the testing.
-Acknowledged that does not always happen.
*Resident 184 had been known to wander the

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facility. Refer to F880, finding 2.

Review of the provider's fit-testing records revealed:
*Staff were last fit-tested in May of 2020.
*The N95 masks they had been fit-tested for were not the masks they were currently wearing.
*None of the staff fit-tested had been medically cleared to wear an N95 respirator.
*ED A and DNS B did not have a timeline for when they would have fit-testing completed.

Review of the provider's May 2015 Infection Control Policies and Practices policy revealed:
*"The objectives of our infection control policies and practices are to:"
-"a. Prevent, detect, investigate, and control infections in the Center;"
-"b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public."
-"c. Establish guidelines for implementing Isolation Precautions, including Standard and Transmission-Based Precautions;"
-"d. Establish guidelines for the availability and accessibility of supplies and equipment necessary for Standard Precautions."
-"e. Maintain records of incidents and corrective actions related to infections; and"
-"f. Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment."
*"5. The Executive Director (ED) or Governing Board, through the QAPI and the Infection Control Committees, have adopted our infection control policies and practices, as outlined herein, to reflect the Center's needs and operational requirements for preventing transmission of infections and communicable diseases as set

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forth in current OBRA [omnibus budget reconciliation act], OSHA [Occupational Safety and Health Administration], and CDC [centers for disease control and prevention] guidelines and recommendations."

Review of the provider's March 2018 Handwashing/Hand Hygiene policy revealed:
*"Personnel follow the handwashing/hand hygiene procedures to help prevent the spread of infections to the other personnel, residents, and visitors."
*Hand sanitizer should be used:
-"Before and after coming on duty."
-"Before and after direct contact with residents;"
-"Before preparing or handling medications;"
-"Before performing any non-surgical invasive procedures;"
-"Before donning [putting on] sterile gloves."
-"Before handling clean or soiled dressings, gauze pads, etc."
-"Before moving from a contaminated body site to a clean body site during resident care."
-"After contact with a resident's intact skin."
-"After contact with blood or bodily fluids."
-"After handling used dressings, contaminated equipment, etc."
-"After contact with objects (e.g. [for example] medical equipment) in the immediate vicinity of the resident; and"
-"After removing gloves."
-"Before and after entering isolation precaution settings;"
-"Before and after eating or handling food;"
-"Before and after assisting a resident with meals; and"
-"After personal use of the toilet or conducting your personal hygiene."

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Review of the provider's May 2015 Standard Precautions policy revealed:
*"Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard Precautions presume that all blood, body fluids, secretions, and excretions (except sweat), not-intact skin and mucous membranes may contain transmissible infectious agents."
*"3. Masks, Eye Protection, Face Shields"
-"a. Wear a mask and eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and resident-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions."

Review of <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html> September 2021, CDC Strategies for Optimizing the Supply of N95 Respirators, accessed 11/9/21 revealed:
*"N95 respirators are the PPE most often used to control exposures to infectious pathogens transmitted via the airborne route, though their effectiveness is highly dependent upon proper fit and use. N95 respirators are intended to be used once and then properly disposed of and replaced with a new N95 respirator. The optimal way to prevent airborne transmission is to use a combination of interventions from across the hierarchy of controls, not just PPE alone. Applying a combination of controls can provide an additional degree of protection, even if one intervention fails or is not available."
*"While engineering and administrative controls should be considered first when selecting controls, the use of personal protective equipment (PPE) should also be part of a suite of

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F 880	Continued From page 145 strategies used to protect personnel. Proper use of respiratory protection by HCP requires a comprehensive program (including medical clearance, training, and fit testing) that complies with OSHA's Respiratory Protection and a high level of HCP involvement and commitment. The program should also include provisions for the cleaning, disinfecting, inspection, repair, and storage of respirators used by HCP on the job according to manufacturer's instructions. Proper storage conditions can maximize shelf life of respirators. The following strategies in this section are traditionally used by some healthcare systems. If not already implemented, these strategies can be considered by healthcare settings in the face of a potential N95 respirator shortage before implementing the contingency strategies that are listed further below." Review of <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>, updated September 2021, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes, accessed 11/9/21 revealed: *"Older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens, such as SARS-CoV-2." *"A strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP)." *"Even as nursing homes resume normal practices, they must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death." *"Testing: Anyone with even mild symptoms of	F 880		

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F 880	Continued From page 146 COVID-19, regardless of vaccination status, should receive a viral test as soon as possible." *"Asymptomatic HCP [health care personnel] with a higher-risk exposure and residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5-7 days after the exposure. Criteria for use of post-exposure prophylaxis are described elsewhere." *"Evaluate residents at least daily." *"Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection." *"Actively monitor all residents upon admission and at least daily for fever (temperature =100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in Section: Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection." *"Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection." *"Because some of the symptoms are similar, it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory	F 880		

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infections, based on symptoms alone. Consider testing for pathogens other than SARS-CoV-2 and initiating appropriate infection prevention precautions for symptomatic older adults."
*"A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

B. Based on observation, interview, and policy review, the provider failed to ensure two of two observed RN (F and H) maintained infection control practices during two of two resident dressing changes (1 and 183). Findings include:

1. Observation on 11/15/21 from 9:40 a.m. through 9:56 a.m. of RN F during a dressing change for resident 1 revealed she:
*Removed the dressing supplies out of the treatment cart that included: a large amount of gauze 4 X 4's, Maxorb II (alginate dressing), Optifoam Gentle, chux as a barrier, and a small red zippered case with resident 1's name on it.
*Placed the other dressings on the overbed table.
*Had not sanitized the overbed table or placed a barrier down. The dressings were next to two urinals, one contained urine.
*Washed her hands for approximately 10 seconds and put on gloves.
*Spread the barrier out on the bed.
*Placed the wound cleanser and Aquaphor moisturizing cream on the left top corner of the barrier. *Placed the two packages of dressings and gauze 4 X 4's to the right upper side of the barrier. She moved the wound cleaner to the right upper side of the barrier.

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F 880	Continued From page 148 *Opened the packages that contained the dressings. *Took her pen out of her pocket and put the date on the dressing and put the pen back in her pocket. *Had resident 1 place his feet with shoes on top of the barrier in the middle. *Removed her gloves, moved the garbage can, and then washed her hands for approximately ten seconds. *Answered her walkie talkie that was in the same pocket as her pen. *Removed her gloves and without any hand hygiene she put on a new pair of gloves. *Removed the soiled dressing from the top of his left foot. *Applied skin barrier around the open wound on top of his left foot. *Removed scissors from the red zippered bag, cut a very small piece of the alginate with scissors that were in the red zippered bag. (Had wiped the scissors with wet gauze) *Removed Aquaphor cream from the container several times with her same gloved hands and applied it to his feet and legs. *Put his socks and shoes on him. *Returned the red zippered bag to the treatment cart. *She had not sanitized the scissors after she had used them. Interview on 11/15/21 at 10:00 a.m. with RN F revealed: *That was how she always completed his dressing change. *Did not feel resident 1's shoes and socks had contaminated anything, as the supplies were in the corners. *Agreed she had missed some hand hygiene	F 880		

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opportunities.

2. Observation on 11/16/21 at 11:20 a.m. of RN H during the wound dressing changes for resident 183 revealed she:
*Washed her hands.
*Put on clean gloves and laid clean 4x4's on the resident's bed without providing a clean barrier.
*Removed dressing from resident's sacral area.
*Removed her gloves and washed her hands.
*Put on clean gloves and used wound cleanser and 4x4's from resident's bed to cleanse wound.
*Removed gloves and washed her hands.
*Put on clean gloves and dipped 4x4's from resident's bed in to Vashe wash and packed wound with soaked 4x4's.
*She removed her gloves and washed her hands.
*Put on clean gloves and removed ace wrap and dressing from resident's left heel.
*Left resident's room with gloves on.
*Had not removed her gloves and performed hand hygiene.
*She returned and cleansed wound to left heel with wound cleanser.
*Removed gloves and washed her hands.
*Put on clean gloves and applied betadine soaked 4x4's to left heel and covered with more 4x4's.
*She rewrapped dressing with the dirty ace wrap.

Review of the provider's July 2014 Licensed Nurse Competency Dressing, Technique Aseptic revealed:
*"Provide a clean surface, such as a paper towel, to place treatment supplies in room and a plastic bag for disposal."
*"Remove soiled dressings and dispose in plastic bag with gloves."
*"Wash hands if visibly soiled or use gel hand

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F 880	Continued From page 150 sanitizer if not." *"Open dressing supplies, leave in sterile packages, and place on aseptic field." *"Apply new gloves." *"Perform treatment as ordered." *"Date and initial dressing according to Center procedure." *"Remove gloves and wash hands if visibly soiled or use gel hand sanitizer." Interview with DNS B would have given an opportunity to review the observations and verify if the dressing changes had been completed in a clean manor to prevent a break in infection control. On 11/18/21 at 9:00 a.m. the survey team had requested ED A and DNS B to meet with the team anytime after 11:00 a.m., to discuss findings. They had not come to discuss as of 11/18/21 at 3:00 p.m. when ED A came and requested the team to leave the building without finishing all survey tasks and interviews or conducting an in person exit interview.	F 880		
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—	F 885	Refer to F880	12/22/21

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	435086	A. BUILDING ____ B. WING ____	11/22/2021

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(i) Not include personally identifiable information;
(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and
(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.
This REQUIREMENT is not met as evidenced by:
Based on record review and policy review, the provider failed to notify 10 out of 37 residents (6, 8, 10, 11, 15, 22, 24, 27, 31, and 36), their representatives, or their families when the facility was in a COVID-19 outbreak. Findings include:

1. Interview on 11/9/21 at 9:30 a.m. with the director of nursing services (DNS) B regarding COVID-19 notifications revealed they documented the notifications to residents, their representatives, and/or families in each resident's electronic medical record (EMR).

Review of resident 6, 8, 10, 11, 15, 22, 24, 27, 31, and 36's EMR revealed no documentation of notification COVID-19 outbreak status in the facility.

Review of the provider's May 2021 Limiting the Spread of COVID-19 in Skilled Nursing Facilities policy revealed: *"Centers must inform residents and their representatives by 5 pm the next calendar day with the occurrence of a single

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F 885	Continued From page 152 confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours. Also, updates to residents and their representatives must be provided weekly, or each subsequent time a confirmed infection of COVID-19 is identified and/or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours." Review of the provider's June 2021 COVID-19 Notification Guidelines For Nursing Homes policy revealed: *Notify Residents, Representatives, and Families: -"a. For every confirmed case of a resident or staff member AND/OR if a group of three or more residents or staff have new onset of respiratory symptoms within a 72-hour period (referred to as a "cluster") the following must occur: -"i. Notify residents, representatives, and families by 5 p.m. the next calendar day after the occurrence." -"ii. If you do not have any new confirmed cases or new clusters of 3 or more residents/staff with new onset respiratory symptoms within a given week, you must provide a weekly update." -"iii. Each update must include mitigation actions you are taking."	F 885		
F 886 SS=L	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:	F 886	Refer to F880	12/22/21

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§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not
limited to:
(i) Testing frequency;
(ii) The identification of any individual specified in this paragraph diagnosed with
COVID-19 in the facility;
(iii) The identification of any individual specified in this paragraph with symptoms
consistent with COVID-19 or with known or suspected exposure to COVID-19;
(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the
transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate
to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms
consistent with COVID-19, or who tests positive

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for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state
and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and reference source review, the provider failed to follow outbreak testing procedures for all staff and residents. Findings include:

These failures had the potential to expose all residents, staff, and visiting essential personnel to COVID-19, a viral infection that could lead to serious harm or death.

NOTICE:
On 11/9/21 at 2:40 p.m. an Immediate Jeopardy was identified when the facility failed to ensure:
*Residents had been tested based off potential symptoms of COVID-19, regardless of COVID-19 vaccination status.
*All staff working in the building had been tested for COVID-19 prior to working with residents.
*Staff who were self-testing were testing accurately and the testing process is being monitored.

At the above time, executive director (ED) A and

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director of nursing services (DNS) B were asked for an immediate plan of correction (POC) to ensure all staff working in the facility received education and monitoring for nationally recognized infection control procedures.

PLAN:
On 11/10/21 at 1:40 p.m. the divisional director of clinical operations (DDCO) C, ED A, and DNS B, provided the surveyor with an email that included the final written removal plan. The written removal plan was approved by the long-term care advisor for the department of health on 11/10/21 at 1:50 p.m.

The facility provided the following acceptable removal plan on 11/10/21:
*"1. All staff re-educated on recognizing signs and symptoms of Covid 19. Residents will be tested if they are exhibiting Covid 19 symptoms in accordance with CDC [Centers for Disease Control and Prevention] recommendations and per direction of the local health department. All residents have been continued to be tested every three to seven days during the outbreak status. Residents will also be tested upon notification of covid symptoms Staff will be re-educated on this. All staff educated by 11/9/21 at 11:59 PM. All staff not tin [in] attendance will be educated prior to their next working shift."
*"2. Those who conduct self-testing will continue to complete competency for self-testing by 11/9/21 at 11:59 PM. All those not competencied for self-testing will be prior to their next working shift."
*"3. The center will audit each shift for the above education completed as specified and observational audits for compliance with PPE, and infection control every shift 11/10/21 by

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ED/DNS or designee until substantial compliance is met."

The immediate jeopardy had been removed on 11/11/21 at 9:40 a.m. after verification that the provider had implemented their removal plan. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "F."

1. Interview on 11/9/21 at 1:00 p.m. with registered nurse (RN) G revealed she:
*Stated only licensed nurses were supposed to have been completing the tests.
*Had been aware that had not always happened.
*Had been unable to say whether tests were always read within the 15 minute window.
*Was not sure if she had completed a competency on testing.
*Had not tested resident 184 even though he had been exhibiting COVID-19 like symptoms. Refer to F880, finding 7.

Review of the provider's testing documentation from the most recent facility outbreak beginning on 11/4/21 revealed:
*They had testing documentation from 11/4/21 and 11/8/21-11/9/21.
*Dietary staff Q was not on the testing records for any of the above dates.
-She had been observed in the building without a shield on. Refer to F880, finding 1.
*Certified nursing aide (CNA)s Y, AA, and R had not been tested and had been working in the building during the testing time.
*CNA Z had testing completed on 11/8/21 but there had been no result documented.
Refer to F880, findings 1, 2, 3, 4, 5, 6, and 7.

Review of resident 184's electronic medical

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F 886	Continued From page 157 record (EMR) revealed: *He had been admitted to the facility on 9/29/21. *His diagnoses included: -Sepsis. -Chronic obstructive pulmonary disease (COPD). -Hypertension. -Pulmonary fibrosis. -Dementia. -Ischemic cardio myopathy. *On: -11/12/21 he was noted to be sleepy and needed help putting oral medications in his mouth. -11/2/21 at 9:52 a.m. he had been noted to have an oxygen (02) saturation (sat) rate of 90 percent. -11/2/21 at 8:16 p.m. he had been noted to have an O2 sat rate of 91 percent. -11/3/21 at 11:29 a.m. he had been documented to be more short of breath (SOB) with exertion and confused. -11/3/21 at 11:47 p.m. he was documented to have diminished lung sounds. -11/4/21 at 7:00 a.m. "CNAs reported resident was SOB, resident was laying on his bed with his legs dangling, skin cold to touch, resident did not respond, noted on respirations inhalations were twice as long as expirations, O2 sat 78% on room air, offered resident PRN [as needed] Proventil inhaler. Vitals: O2 sat 78% on room air." -11/4/21 at 7:25 a.m., ": Resident was positioned on his bed, O2 sat increased to 85%, offered resident O2 at 2L [liters] per nasal cannula, resident verbalized pain in Rt. [right] arm when Rt. arm was moved, BP [blood pressure] 104/62, T 97.6, P 87 apical [part where the beat is the loudest], R [respirations] 20 with 20 sec. [second] apnea [absence of breath], skin still cold to touch, lung sounds crackle throughout lobes, bowel sounds present in all four quadrants, abdomen is soft and non-tender, 2+[two plus] edema in Rt.	F 886		

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lower leg and 1+ edema in Lt. [left] lower leg in the posterior leg, noted resident is a full code. Vitals: BP 104/62, T 97.6, P 87, R 20 w/ 20 sec. apnea, O2 sat 85% on room air[.]"
*At 8:00 a.m. on 11/4/21 registered nurse (RN) G called the hospital to get an order to transport resident 184 to the emergency room by ambulance.
*He had been taken by ambulance to the hospital at 8:20 a.m. on 11/4/21.
*At 2:57 p.m. on 11/4/21 DNS B documented that she had called the resident's son to notify him that the hospital informed them resident 184 had tested positive for COVID-19.

Review of the provider's May 2020 provided American Healthcare Association Algorithm for Testing and Cohorting Residents documents revealed:
*"Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or small. Additionally, more than two temperatures >[greater than] 99.0 [degrees] F [Fahrenheit] might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.

Review of the provider's May 2021 Limiting The Spread of COVID-19 in SNF [skilled nursing facility]policy revealed:
*"1. Center-wide surveillance testing is completed based on the CMS [Centers for Medicare and Medicaid Services] county positivity rates determined every Monday morning or in state regulatory guidance if a more stringent frequency

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is required, utilizing a POC [point of care] antigen test, or PCR [Polymerase Chain Reaction] laboratory if POC antigen testing is not available."
*"a. Staff are required to test in accordance with the COVID-19 Testing policy. Those who do not test may be excluded from work. Staff may choose to test through other means, such as through their Primary Care Physician.
*"d. All staff must participate in outbreak testing regardless of vaccination status."
*"e. Staff may self-swab, unsupervised, according to lab directives after training has occurred."
*"1. All residents are continually monitored for signs/symptoms of respiratory illness. If symptoms exist, the resident is placed on Enhanced Droplet Precautions and the provider and center's state department of health are notified."
-"a. Monitoring of residents will occur at least daily, which includes symptom monitoring (cough, shortness of breath or difficulty breathing, fever, chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorders(s); consider also rhinorrhea, diarrhea, nausea or vomiting), temperature, and other vital signs, including pulse oximetry."

Review of the provider's May 2020 COVID-19 Testing Flowsheet revealed:
*It included the steps that should be taken during an outbreak which included:
-Resident name.
-Test date.
-Test Type.
-Testing Consent.
-If the resident was currently on transmission-based precautions.
-Completion of the screening form.
-Who was completing the testing.

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-Test result date.
-Test result.
-Notification of the Health Department.
-Notification of positive test by five p.m. the next calendar day.
-Report completed to NHSN (national healthcare safety network).
-Completion of the provider's outbreak action plan.
-Implementation of Isolation.
-Hand Hygiene and personal protective equipment observations.
-Increased screening and observations.
-Resident's care plans updated.
*The provider had not been utilizing this form.
2. Interview on 11/15/21 at 2:25 p.m. Minimum Data Set (MDS) coordinator I revealed:
*She assisted with the COVID-19 testing.
*They tested the staff today.
*The list of who was tested and the results is on a clipboard at the second floor nurses station.
*The nurses on duty do the staff testing.
*She was not sure when the residents would be tested again as the resident who had been positive was no longer in the building.
*She then stated all the residents would be tested on 11/16/21.

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FORM APPROVED
OMB NO. 0938-0391

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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 11/15/21 through 11/18/21, with the exit conducted on 11/22/21. Riverview Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Timothy Yeaton
TITLE — Executive Director
(X6) DATE — 12/17/2021

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.

DEC 17 2021

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/16/21. Riverview Healthcare Center (building 01) 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 health care occupancies upon correction of deficiencies identified at K293, K353 and K355 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 293 SS=E	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: Surveyor: 27198 Based on observation and interview, the provider failed to maintain exit lighting for 3 randomly observed locations (main entrance stair landing, end of lower-level west wing and, staff breakroom). Findings include: 1. Observation beginning on 11/16/21 at 12:45 p.m. revealed the exit sign mounted above the	K 293	1. All residents have the potential to be affected. 2. All signage on order and scheduled to arrive and be installed by 1/15/22. ED educated Maintenance on ensuring exit signage remains in working order by 12/22/21. 3. The ED or designee will audit all exit signage monthly times six months to ensure it is in working order once signage is replaced. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Yeaton	Executive Director	12/17/21

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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K 293	Continued From page 1 main entrance stair landing had one of two incandescent lamps not functioning in the fixture. Interview with the maintenance director at the time of the observation confirmed that condition. He stated that type of fixture was old and difficult to maintain. The deficiency affected two locations required to be provided with a marked and identifiable path of egress. 2. Observation beginning on 11/16/21 at 1:05 p.m. revealed the exit sign mounted above the exit door for the west wing in the lower-level had one of two incandescent lamps not functioning in the fixture. Interview with the maintenance director at the time of the observation confirmed that condition. He stated that type of fixture was old and difficult to maintain. The deficiency affected two locations required to be provided with a marked and identifiable path of egress. 3. Observation beginning on 11/16/21 at 2:45 p.m. revealed the exit sign mounted above the exit from the staff breakroom did not have lamps functioning in the fixture. Interview with the maintenance director at the time of the observation confirmed that condition. The deficiency affected two locations required to be provided with a marked and identifiable path of egress.	K 293		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	**611 EAST 2ND AVE** **FLANDREAU, SD 57028**

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K 353 K 353 SS=E	Continued From page 2 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: Surveyor: 27198 Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done in 2021). Findings include: 1. Record review on 11/16/21 at 3:10 p.m. revealed the required quarterly flow tests had not been performed in the past year. Interview with maintenance director at the time of the record review confirmed that condition. He stated he was not aware of the requirements for sprinkler system quarterly flow tests. Failure to continuously maintain the automatic	K 353 K 353	1. All residents have the potential to be affected. 2. The sprinkler system company will train the ED and maintenance director on quarterly flow testing by 1/7/21. The ED educated the maintenance director on the importance of quarterly flow testing by 12/22/21. 3. The ED or designee will audit quarterly times two quarters that flow testing has been completed on training on flow testing has occurred. The ED or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.	12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING 01 - **MAIN BUILDING 01** B. WING ______	**11/16/2021**

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RIVERVIEW HEALTHCARE CENTER	**611 EAST 2ND AVE FLANDREAU, SD 57028**

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K 353	Continued From page 3 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 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to inspect three randomly observed fire extinguishers (laundry room, boiler room, and smoking area). Findings include: 1. Observation and interview on 11/16/21 at 10:58 a.m. revealed inspection tag on the extinguisher in the laundry room showed it had not received the required monthly inspections since September of 2021. Interview with the maintenance director at the time of the observation confirmed that finding. He stated he was unaware that fire extinguisher had not been inspected since September of 2021. The deficiency has the potential to affect the entire smoke compartment. 2. Observation and interview on 11/16/21 at 11:26 a.m. revealed inspection tag on the extinguisher	K 355	1. All residents have the potential to be affected. All fire extinguishers have been inspected prior to 12/22/21. 2. The ED educated the maintenance director on the importance of monthly fire extinguisher inspections and maintenance by 12/22/21. 3. The ED or designee will audit all fire extinguishers monthly times four months for timely inspection and maintenance. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW HEALTHCARE CENTER	611 EAST 2ND AVE FLANDREAU, SD 57028

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K 355	Continued From page 4 in the boiler room showed it had not received the required monthly inspections since June of 2021. Interview with the maintenance director at the time of the observation confirmed that finding. He stated he was unaware that fire extinguisher had not been inspected since June of 2021. The deficiency has the potential to affect the entire smoke compartment. 3. Observation and interview on 11/16/21 at 1:22 p.m. revealed inspection tag on the extinguisher in the outdoor smoking area showed it had not received the required monthly inspections since its annual inspection on 3/11/21. Interview with the maintenance director at the time of the observation confirmed that finding. He stated he was unaware that fire extinguisher had not been inspected since its annual inspection. The deficiency has the potential to affect the entire smoke compartment.	K 355		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **02 - 1989 ADDITION** B. WING	**11/16/2021**

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RIVERVIEW HEALTHCARE CENTER	**611 EAST 2ND AVE** **FLANDREAU, SD 57028**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/16/21. Riverview Healthcare Center (building 02) 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 health care occupancies upon correction of deficiency identified at K351 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351	1. All residents have the potential to be affected. 2. A new sprinkler will be installed by 1/7/2022. The ED educated the maintenance director on the requirements of a fully sprinkled facility by 12/22/21. 3. The ED will audit the unsprinkled area one time after installation is finished. The ED will bring the result of this audit to the monthly QAPI committee for review.	12/22/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Yeaton	*Executive Director*	*12/17/21*

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435086	A. BUILDING **02 - 1989 ADDITION** B. WING ______	**11/16/2021**

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K 351	Continued From page 1 by: Surveyor: 27198 Based on observation and interview, the provider failed to provide sprinkler protection throughout the facility as required. An area within maintenance shop/storage room was not covered by the automatic fire sprinkler system. Findings include: 1. Observation on 11/16/21 at 10:15 a.m. revealed a portion of the staff maintenance shop/storage room (air conditioner storage area) was not covered by the fire sprinkler system. That room was of combustible construction with the ceiling open to the wood floor and truss system above. The deficiency could affect 100% of the building occupants.	K 351		

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
	10620	A. BUILDING: ______ B. WING ______	11/22/2021

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RIVERVIEW HEALTHCARE CENTER	611 E 2ND AVE FLANDREAU, SD 57028

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S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/15/21 through 11/18/21, with the exit conducted on 11/22/21. Riverview Healthcare Center was found not in compliance with the following requirement(s): S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation, testing and interview, the provider failed to maintain exhaust ventilation as required in two randomly observed locations (upper and lower-level tub/shower rooms). Findings include: 1. Observation on 11/16/21 at 1:25 p.m. revealed the tub/shower room in the lower-level had a ventilation register in the ceiling by the door. Testing at that same time revealed that vent was not providing any exhaust ventilation. Further observation at that same time revealed there was no other ventilation registers in that room Interview with the maintenance director at the time of the observation confirmed the vent was not working. 2. Observation on 11/16/21 at 2:17 p.m. revealed	S 157	1. All residents have the potential to be affected. 2. The ventilation company was in the center on 12/15/21 and repaired ventilation units with the exception of one area that new parts for the motor were needed. Parts are expected to arrive in the next week. Ventilation in this area will be repaired by 1/15/22. The ED educated the maintenance director on the requirement of working ventilation systems by 12/22/21. 3. The ED or designee will audit a random sample of 4 ventilated areas weekly times four weeks and monthly times two months to ensure they are in working order. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	12/22/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Timothy Yeaton	Executive Director	12/17/21

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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
	10620	A. BUILDING: ______ B. WING ______	11/22/2021

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S 157	Continued From page 1 the tub/shower room in the upper-level had a ventilation register in the celling by the door. Testing at that same time revealed that vent was not providing any exhaust ventilation. Further observation at that same time revealed there was no other ventilation registers in that room Interview with the maintenance director at the time of the observation confirmed the vent was not working.	S 157		