STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	125023		08/11/2022

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F 000	INITIAL COMMENTS	F 000		
	A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on August 8 - 11, 2022. The facility was found not to be in substantial compliance with 42 CFR §483, Subpart B. Survey Dates: 08/08/2022 - 08/11/2022 Survey Census: 10			
F 550 SS=D	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	F 550		8/26/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2022

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

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F 550	Continued From page 1 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to protect and promote quality of life for three residents (Residents 3, 6, and 5) in the sample by ensuring that they were treated with respect and dignity. Specifically, the facility failed to ensure staff provided feeding assistance in a manner that promoted independence and dignity. As a result of this deficient practice, these residents had their dignity compromised and were placed at risk of a decreased quality of life. This deficient practice has the potential to affect all residents in the facility who receive assistance with feeding. Findings include: 1) On 08/08/22 at 11:40 AM, observed certified nurse aide (CNA)1 standing over Resident (R)3 while assisting him with eating. A review of his Minimum Data Set (MDS) Quarterly Review Assessment with an Assessment Reference Date (ARD) of 07/05/22 noted that R3 was totally dependent on staff for eating.	F 550	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 8/9/2022, just in time education was provided to (CNA)1 and (CNA)2 regarding the need to sit next to the resident while assisting with eating. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents requiring assistance with eating have the potential to be affected. On 8/11/22, just in time education provided to all care staff working regarding the need to sit next to the resident while assisting with eating.	

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F 550	Continued From page 2 2) On 08/08/22 at 11:45 AM, observed CNA2 standing over R6 as she assisted her with eating. A review of her MDS Quarterly Review Assessment with an ARD of 04/25/22 noted that R6 was totally dependent on staff for eating. 3) On 08/08/22 at 11:56 AM, observed CNA2 standing over R5 as she fed him three (3) spoonfuls of his prune pudding before returning the spoon to him and allowing him to feed himself the remainder. The prune pudding was the only item left on his lunch tray after independently feeding himself the rest of his lunch. A review of his MDS Quarterly Review Assessment with an ARD of 07/07/22 noted that R5 had been determined to require "Limited assistance - resident highly involved in activity [eating]; staff provide guided maneuvering of limbs or other non-weight-bearing assistance" for eating.	F 550	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 8/26/22, education provided to all care staff regarding Resident Rights and Dignity HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Charge Nurse will perform a weekly observational audit of care staff assisting with eating to ensure care staff are seated next to the resident while assisting with eating. Results of the audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(I) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the	F 583		8/26/22

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F 583	Continued From page 3 residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to respect the right to personal privacy for one resident (R) in the sample (R4). Specifically, the facility installed a baby monitor camera in his room, placing him under continuous video monitoring, without his consent. As a result of this deficient practice, R4 had his privacy compromised and was placed at risk of a decreased quality of life and psychosocial harm. This deficient practice has the potential to affect all the residents at the facility. Findings include: Resident (R)4 is a 90-year-old male admitted to the facility on 04/02/21. His diagnoses include	F 583	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident(R4) has been determined by his physician to be non-decisional for healthcare. On 8/17/22, consent was obtained from the resident's(R4) designated POA to allow for the use of video monitoring for the resident's safety. The room privacy curtain will be drawn to block the camera during times of personal care or if the resident is engaging in sexual activity. The video camera being utilized does not connect to an outside network or the internet. Therefore, it	

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F 583	Continued From page 4 failure to thrive, major depressive disorder, anxiety disorder, and dementia with behavioral disturbance. On 08/08/22 at 03:38 PM, a review of his Minimum Data Set (MDS) Quarterly Review Assessment with Assessment Reference Dates (ARD) of 04/11/22 and 07/11/22 noted that R4's Brief Interview for Mental Status (BIMS) exams had evaluated him with a score of 14. A score of 13-15 indicates the interviewee is "cognitively intact." Both assessments also documented no acute changes in mental status. Further review of R4's medical record at this time revealed the following physician order from 12/06/21: "Start [behavior] monitoring... 3. Paranoid, e.g. thinking that someone is monitoring him and setting up cameras and bugs on some items in his room or wherever he is located ..." The behavior monitoring was in relation to a psychiatric medication ordered for R4. On 08/10/22 at 02:36 PM, during an observation and concurrent interview with the Charge Nurse (CN)1, observed a video camera/monitor that had been set up in R4's room. The camera/monitor faced R4's bed and transmitted a live video feed to a receiver at the Nurses' Station (NS). CN1 stated the camera/monitor had been set up as an intervention to reduce falls for R4. CN1 confirmed at this time that R4 was still being monitored for, and exhibiting signs of, paranoia that he was being monitored/watched without his consent. A copy of R4's signed consent for the video monitoring was requested. On 08/10/22 at 03:02 PM, an interview was done	F 583	would require any unauthorized users to be in the same proximity (in the building) due to the short range of the video camera transmission. This eliminates the possibility of anyone remotely accessing the video monitoring. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: On 8/12/22, a review of all other residents was performed. No other residents were identified with video monitoring in their rooms WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 8/26/22, education was provided to all care staff regarding Personal Privacy. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly, the Charge Nurse will review all residents with video monitoring to ensure a consent is in place for the video monitoring. Results of the audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at	

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F 583	Continued From page 5 with the Director of Nursing (DON) in the Treatment/Activity Room. The DON acknowledged R4's history of and continued monitoring for paranoid delusions related to being monitored by cameras and explained that the camera/monitor had begun in January 2022 to help prevent falls. A review of the Nursing Progress Notes in R4's medical record confirmed a 01/21/22 Progress Note (PN) documenting "baby monitor placed in his room." Another PN on 01/22/22 noted "His POA [Power of Attorney] is aware of the monitor in the room." Review of the medical record could find no documentation that R4 himself was aware of the monitor in his room. On 08/10/22 at 03:10 PM, during a brief discussion in the area between the NS and the Emergency Room, the Administrator confirmed that there was no other documentation found indicating that signed or verbal consent had been obtained.	F 583	the QAPI meeting.	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview with staff members, the facility did not assure 2 (Residents 10 and 1) of 9 residents in the sample received an accurate assessment for the use of antibiotics and accurately code a resident's activities of daily living abilities in bed mobility and transfer. Findings include:	F 641	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 8/12/22, a correction was made to the MDS for resident (R1) to reflect the corrected coding of antibiotic use.	8/24/22

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F 641	Continued From page 6 1) Resident (R)10 was admitted to the facility on 03/18/21 from an acute hospital. Diagnoses include cerebrovascular accident, diabetes mellitus, and hypertension. Record review of R10's comprehensive/annual Minimum Data Set (MDS) with an assessment reference date (ARD) of 03/24/22 notes R10 was coded for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture) and transfer (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position) as requiring extensive assist with two plus person physical assist. Review of the subsequent quarterly MDS with an ARD of 06/23/22 documents R1 was coded as dependent with two plus person physical assist for bed mobility and transfer, indicating a decline in self-performance. Interview with Resident Assessment Instrument Coordinator (RAIC) was done on 08/09/22 at 03:44 PM, inquired what contributed to R1's decline in self-performance for bed mobility and transfer. RAIC was agreeable to review certified nurse aides' charting. RAIC explained extensive assist would indicate the resident could bear some weight (stand-lift) and using a Hoyer lift for transferring would indicate the resident is dependent. At 04:23 PM, RAIC reported R10's record was reviewed back to December 2021 and R10 has always been dependent in self-performance for bed mobility and transfer. RAIC acknowledged this was a coding error and not a decline. 2) R1 was readmitted to the facility on 04/24/22	F 641	On 8/12/22, a correction was made to the MDS for resident (R10) to reflect the corrected coding of the Bed Mobility and Transfer. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. By 8/22/22, all coding for residents with antibiotic use in the past 6 months were reviewed for accuracy and correction made as appropriate. By 8/22/22 all coding for residents with any changes in the past 6 months to coding for Bed Mobility or Transfer were reviewed for accuracy and corrections made as appropriate. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 8/18/22, education on MDS coding of ADL functions was provided to the Director of Nursing by the MDS Coordinator. Previous process was for the MDS Coordinator to review for completion prior to submission. On 8/24/22, a double check process was implemented where the MDS Coordinator will review for accuracy all data submitted by the Director of Nursing prior to data submission to MDS.	

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F 641	Continued From page 7 after being treated for COVID-19 and a urinary tract infection (UTI). Diagnoses include unspecified dementia without behavioral disturbance. Record review found a physician progress note dated 08/08/22 documenting R1 has recurrent UTI with staghorn calculus in the right kidney which requires surgery. The recommendation was antibiotic suppression, administration of Vantin (antibiotic) either continuously or until surgery can be scheduled. A review of the Medication Order for August 2022 notes a physician's order for cefpodoxime 200 mg tablet (for Vantin) once daily continually for diagnosis of UTI. The start date was 04/28/22. A review of R1's annual/comprehensive MDS with an ARD of 06/14/22 in Section N. Medications, R1 was coded as receiving antibiotic once during the last seven days. Review of the care plan revealed no plan/interventions for the long-term use of an antibiotic. A review of R1's Medication Administration Record (MAR) for June documents cefpodoxime (Vantin) was administered daily as ordered. On 08/10/22 at 10:00 AM, an interview and concurrent record review was done with the RAIC. RAIC reviewed the MDS and MAR and confirmed there was a coding error. R1 should be coded 7 (seven) indicating R1 received an antibiotic medication for seven days during the assessment period.	F 641	HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly, the MDS Coordinator will audit for accuracy any MDS submissions for antibiotic use, bed mobility, and transfer. Results of the audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans	F 657		8/26/22

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F 657	Continued From page 8 §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview with staff member, the facility failed to revise a care plan to reflect change in a resident's (Resident 2) need for passive range of motion services. Findings include: Resident (R)2 was admitted to the facility on 05/20/10 from a hospital. Diagnoses include progressive supranuclear palsy, diabetes mellitus (Type II), osteoarthritis, chronic obstructive	F 657	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 8/12/22, the care plan for the resident (R2) was updated to be in alignment with physician orders and the Maintenance Exercise Program (MEP). HOW THE FACILITY WILL IDENTIFY	

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F 657	Continued From page 9 pulmonary disease, and dysphagia. A review of the quarterly Minimum Data Set (MDS) with assessment reference date of 07/11/22 noted in Section G0400. Functional Range of Motion, R2 is coded with impairment to upper and lower extremities, both sides (right and left). Review of R2's care plan for contractures include a "description" for the resident to wear bilateral elbow wedge throughout the day 2 hours on/2 hours off as tolerated and to provide passive range of motion (PROM) to bilateral upper extremities before and after donning/doffing (putting on/removing) wedge. The interventions include, observe for and document any noted further contractures, perform range of motion exercises as ordered, and keep resident's hands clean and dry, nails trimmed and filed. The start date for this care plan was 07/01/21 with an expected end date of 09/30/22. On 08/10/22 at 03:00 PM an interview and concurrent record review was conducted with the Charge Nurse (CN)1. Requested to review documentation of staff members providing passive range of motion. CN1 provided documentation of staff members providing range of motion (ROM) daily. Reviewed the care plan with CN1 that indicates for staff to provide PROM to bilateral upper extremities before and after donning/doffing of wedge. CN1 replied that they are providing ROM services as ordered by the physician. Review of R2's physician orders for August 2022 with CN1 include placing a wedge to right and left elbows for 2 hours or as tolerated (dated 03/11/20) and maintenance exercise program PROM upper extremities/lower extremities 5 (five) times per week (dated 06/05/19). CN1 acknowledged R2's care plan	F 657	OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents have the potential to be affected. On 8/18/22, all resident charts were reviewed to ensure the mobility care plan is in alignment with current physician orders and MEP. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: At the monthly IDT meeting, the IDT will review the mobility care plans to ensure they are in alignment with current physician orders and MEP. By 8/26/22, all nurses were provided education on the need to update care plans when there are changes to physician orders and MEP. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly, the Charge Nurse will perform an audit of all resident mobility care plans to ensure they are in alignment with current physician orders and MEP. Results of the audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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F 657	Continued From page 10 needs revision to match the physician's orders.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assess for, document, and manage, lower leg edema for one Resident (R) in the sample who had a diagnosis and was being actively treated for it. As a result of this deficient practice, the Resident was placed at an increased risk for avoidable declines and injuries related to lower leg edema. This deficient practice has the potential to affect all residents at the facility at risk of lower leg edema. Findings include: Resident (R)5 is an 81-year-old male admitted to the facility on 09/08/17. His diagnoses include alcohol-related dementia with behavioral disturbance, bilateral [both sides] leg edema, chronic bilateral peripheral venous insufficiency [when your leg veins become damaged and can't work as they should. Normally, valves in your leg veins keep blood flowing back up to your heart. Damage to those valves causes blood to pool in your legs. This increases pressure in your leg	F 684	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 8/9/22, staff working with resident (R5) provided just in time education on how to elevate legs for edema control. On 8/15/22 nursing started assessing every shift the lower limb edema for resident (R5) to determine the effectiveness of the treatment. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: All residents with orders to elevate lower extremities for edema have the potential to be affected. By 8/17/22, all residents with orders to elevate lower extremities for	8/26/22

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F 684	Continued From page 11 veins causing symptoms like swelling], and hypertension [high blood pressure]. On 08/08/22 at 11:16 AM, an observation was done of R5 sitting near the window in the dining room. R5 was sitting in a wheelchair with his feet placed on the footrests in the down position (knees bent at approximately ninety (90) degrees). R5 was wearing long pants, non-slip socks, and a lap blanket; unable to observe skin condition or swelling in his legs. Continued observations throughout the day noted no change in position of his legs or footrests until he returned to his room to lay on his bed at approximately 01:30 PM. On 08/09/22 at 08:26 AM, during a review of R5's medical record, the following order from 07/02/20 was noted: "Elevate legs between meals for 30 minutes (resident may be in chair with legs up or in bed) - DX [diagnosis]: Bilateral Leg Edema [swelling]." On 08/09/22 at 08:53 AM, an observation was done of R5 sitting near the window in the dining room. R5 was sitting in a wheelchair with his feet placed on the footrests in the down position (knees bent at approximately ninety (90) degrees), wearing shorts. R5's lower legs, ankles, and feet appeared swollen with his skin drawn taut. Continued observations throughout the day noted no change in position of his legs or footrests until he returned to his room to lay on his bed at approximately 01:30 PM. On 08/10/22 at 11:12 AM, an observation was done of R5 sitting near the window in the dining room. R5 was sitting in a wheelchair with his feet	F 684	edema were reviewed to ensure the lower extremities are being elevated as ordered and that an assessment is performed every shift to determine the effectiveness of the treatment. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 8/26/22, educated all care staff regarding how to appropriately elevate lower extremities to reduce edema. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The Charge Nurse will perform weekly observational audits of residents with orders to elevate lower extremities to ensure the elevation is being performed correctly. The Charge Nurse will also perform weekly documentation audits to ensure the assessments for effectiveness of the treatment are being performed every shift. Results of the audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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F 684	Continued From page 12 placed on the footrests in the down position (knees bent at approximately ninety (90) degrees). Interviews were done concurrently with Certified Nurse Aide (CNA)2 and CNA3. CNA3 stated that they [the CNAs] elevate R5's legs on the footrests of his wheelchair or a short stool (pointing to a 2-inch flat stool) for his edema. Both CNAs agreed that this treatment is done once a day after breakfast, and that they considered R5's legs currently elevated, placed on his footrests in the down position. CNA3 further explained that the footrests on R5's wheelchair cannot go any higher than they already were. CNA2 stated that when R5 returns to bed after lunch, they will elevate his feet on a pillow. On 08/10/22 at 11:30 AM, an interview was done with the Director of Nursing (DON) in the Treatment/Activity Room. When asked for documentation that R5's edema was being assessed and monitored for treatment efficacy, the DON produced a copy of R5's Treatment Record which listed different treatments ordered, including to "Elevate legs between meals." The "Elevate legs" treatment had 0900, 1300, and 1800 [09:00 AM, 01:00 PM, and 06:00 PM] written in next to it, and included the initials of the licensed nurses on duty in the daily columns. The DON explained that the initials indicated both that the treatment had been done and that the edema had been assessed. If the licensed nurse on duty had found evidence of edema, they would put it in a Progress Note. When asked if that meant R5 was being routinely assessed for edema three times a day, the DON stated, "yes, they [the licensed nurses] do it every shift." On 08/10/22 at 11:42 AM, an interview was done	F 684		

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F 684	Continued From page 13 with Registered Nurse (RN)1 in the Dining Room. When asked if he routinely assessed any of the residents for edema, RN1 responded, "no." RN1 stated that he would assess for edema only if he noticed it while doing his visual check of the resident(s) at the start of his shift, or if a CNA alerted him that there was a problem. On 08/10/22 at 12:22 PM, during an interview with the DON in the Treatment/ActivityRoom, the DON stated that she had completed a review of the Progress Notes and had not seen any documentation of edema for "a long time, so he [R5] doesn't really need it anymore." When asked why they were continuing an active treatment if the resident did not need it, the DON stated, "it seems to be working, he hasn't had edema, so we do it preventively." On 08/10/22 at 12:39 PM, the State Agency (SA) accompanied the DON and Charge Nurse (CN)1 into R5's room to assess for lower leg edema, at the SA's request. The SA observed at this time that neither CN1 or the DON assessed for edema properly, lightly pressing down on R5's foot and shin for less than a second in different areas. The SA had to prompt the DON to hold light pressure for a few seconds before letting go. Once this was done, the DON agreed that R5 had "+1 edema ... on one side [left]." A review of Clinical manifestations and Evaluation of Edema in Adults, by C. Christopher Smith, MD, found at https://www.uptodate.com/contents/clinical-manifestations-and-evaluation-of-edema-in-adults/print, and current through July 2022, revealed the following: " ... edema is defined by the presence of tissue depression after pressure is applied to	F 684		

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F 684	Continued From page 14 the edematous area for at least five seconds." A review of Patient Education: Edema (swelling) (Beyond the Basics), by Richard H Sterns, MD, found at https://www.uptodate.com/contents/edema-swelling-beyond-the-basics/print, and current through July 2022, revealed the following: "Leg, ankle, and foot edema can be improved by elevating the legs above heart level for 30 minutes three or four times per day."	F 684		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a Director of Nursing (DON) on a full-time basis. The same staff member covers both the long-term care (LTC) facility and the Critical Access Hospital (CAH) as the DON. Findings include:	F 727	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were identified as being affected by the deficient practice	9/1/22

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F 727	Continued From page 15 On 08/10/22 at 01:45 PM, Administrator reported the facility's Director of Nursing (DON) oversees the LTC facility and the CAH. On 08/11/22 at 02:46 PM, the facility provided a job description for the LTC DON via secure email. The job title is Director of Nursing - Critical Access. The job summary includes providing leadership and on-going management of the hospital's daily administrative services and responsible for staffing, planning, development, implementing, controlling and evaluation of the hospital's operations to ensure quality patient services are provided. On 08/15/22 at 11:15 AM, the facility provided a snapshot of the facility's organizational chart. The staff member in the DON position is listed as the DON for the LTC facility and the Critical Access Hospital.	F 727	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: No residents were identified as being affected by the deficient practice WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week, and Lanai Community Hospital has a physician onsite 24/7 as well as on call physician coverage. Further, Lanai Community Hospital□s full capacity is well below an average daily census of 60. Lanai Community Hospital has requested a waiver on 9/1/2022 for the requirement of a full time Director of Nursing under ¿ 483.35 (b)(3) and ¿ 483.35 (f)(1)(i)(ii). Assuming the waiver is approved, the waiver will allow for 1 Director of Nursing (DON) to oversee the Critical Access Hospital (CAH) and the Long-Term Care (LTC) facility. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: The facility will apply for the waiver yearly to maintain compliance with Federal Regulation.	

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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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one resident (R) diagnosed with dementia, received the appropriate treatment and services to attain or maintain his highest practicable physical, mental, and psychosocial well-being. Specifically, the resident was administered psychiatric medication mixed into his food and was being monitored in his room via a live video monitor, both without his consent or knowledge, despite explicitly expressing paranoia and anxiety about those events. As the resident had been receiving dementia care services for previously diagnosed psychiatric issues such as paranoid delusions, the psychosocial harm and potential for negative effects as a result of this deficient practice cannot be fully determined, however, it is known that this deficient practice has the potential to affect all the residents at the facility receiving dementia care. Findings include: Resident (R)4 is a 90-year-old male admitted to the facility on 04/02/21. His diagnoses include failure to thrive, major depressive disorder, anxiety disorder, and dementia with behavioral disturbance. On 08/08/22 at 03:38 PM, a review of his Minimum Data Set (MDS) Quarterly Review	F 744	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 8/12/22, a detailed care plan was implemented for the resident (R4). The resident□s care plan now reflects that the resident is accepting of taking liquid medications via PO syringe. The resident□s medication is no longer mixed in his food. On 8/17/22, a detailed care plan was implemented for the same resident (R4) regarding the use of video monitoring. The care plan addresses the problem of the resident□s paranoia of being watched on camera. Resident(R4) has been determined by his physician to be non-decisional for healthcare. On 8/17/22, consent was obtained from the resident□s(R4) designated POA to allow for the use of video monitoring for the resident□s safety. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN:	8/26/22

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F 744	Continued From page 17 Assessment with Assessment Reference Dates (ARD) of 04/11/22 and 07/11/22 noted that R4's Brief Interview for Mental Status (BIMS) exams had evaluated him with a score of 14. A score of 13-15 indicates the interviewee is "cognitively intact." Both assessments also documented no acute changes in mental status. Further review of R4's medical record at this time revealed the following physician order from 12/06/21: "Start monitoring... Delusion of Grandeur, e.g. believing that he is an Archangel who can save others ... 2. Delusion of Persecution, e.g. believing that some staff are devil and demons who will hurt him... 3. Paranoid, e.g. thinking that someone is monitoring him and setting up cameras and bugs on some items in his room or wherever he's located ... someone must have added poison on his food or drink, hence prefers sealed bottled water and not to take medication." On 08/10/22 at 02:36 PM, during an observation and concurrent interview with Charge Nurse (CN)1, observed a video camera/monitor that had been set up in R4's room. The camera/monitor faced R4's bed and transmitted a live video feed to a receiver at the Nurses' Station (NS). CN1 stated the camera/monitor had been set up as an intervention to reduce falls for R4. CN1 confirmed at this time that R4 was still being monitored for, and exhibiting signs of, paranoia that he was being monitored/watched without his consent. A copy of R4's signed consent for the video monitoring was requested. On 08/10/22 at 03:02 PM, an interview was done with the Director of Nursing (DON) in the Treatment/Activity Room. The DON	F 744	On 8/12/22, all resident care plans reviewed to ensure detailed interventions are in place for any other residents that have medication mixed into their food or have video monitoring. No other residents were identified as having their medications mixed into their food or have video monitoring. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly, the Interdisciplinary Team (IDT) will perform a detailed review of the comprehensive care plans to ensure detailed interventions are in place for any residents that have their medication mixed into their food and that an informed consent has been obtained from the resident or POA. By 8/26/22, education provided to all nurses regarding the development of a comprehensive care plan. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly, the Director of Nursing will audit all residents that have their medication mixed into their food and/or video monitoring to ensure a care plan with detailed interventions is in place and that an informed consent from is in place when either practice is being performed. Results of the audits will be reviewed at the monthly QAPI meeting to ensure the	

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F 744	Continued From page 18 acknowledged R4's history of and continued monitoring for paranoid delusions related to being monitored by cameras and explained that the camera/monitor had begun in January 2022 to help prevent falls. A review of the Nursing Progress Notes in R4's medical record confirmed a 01/21/22 Progress Note (PN) documenting "baby monitor placed in his room." Another PN on 01/22/22 noted "His POA [Power of Attorney] is aware of the monitor in the room." Review of the medical record could find no documentation that R4 was aware of the monitor in his room. On 08/10/22 at 03:10 PM, during a brief discussion in the area between the NS and the Emergency Room, the Administrator confirmed that there was no other documentation found indicating that signed or verbal consent had been obtained. On 08/10/22 at 04:55 PM, an observation was done of Registered Nurse (RN)1 preparing to administer the following psychiatric medications to R4: Aripiprazole [an antipsychotic] 1mg/ml [milligram per milliliter] liquid, 2 mls [milliliters], may mix with food or drinks. Citalopram [an antidepressant] 10mg/5ml solution, 2.5 mls, may mix with food or drinks. After preparing the colorless liquids/solutions, observed RN1 pour both doses all over the main dish (chicken with a thin gravy) in R4's partitioned dinner plate. RN1 then handed the dinner tray to Certified Nurse Aide (CNA)4, who delivered the dinner tray to R4. Neither RN1 nor CNA4 informed R4 that there was medication in his	F 744	corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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F 744	Continued From page 19 food. When asked, RN1 stated that R4 could feed himself and that the medications were poured onto his food "because he thinks his medicine is a poison." RN1 then proceeded to continue his afternoon medication pass, moving on to the next resident. On 08/10/22 at 05:11 PM, observed R4 inform the Director of Nursing (DON) that he was done with his dinner tray. The DON took R4's dinner tray from him and placed it on the meal cart to go back to the kitchen. An inspection of the dinner tray at this time noted all but one small piece of minced chicken was gone from the main dish section of the plate, however thin gravy still remained in the bottom of the partition. Despite it being impossible to determine how much of each medication R4 received (whether he accidently dropped some of the food, shared some of the food with another resident, diverted food into his napkin, or how much medication may or may not have been left in the plate), RN1 documented both medications as fully administered. On 08/11/22 at 07:45 AM, during a review of his medical record, it was noted that R4 was informed of and allowed to refuse other medications that were not psychiatric.	F 744		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		8/11/22

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F 755	Continued From page 20 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure pharmacy services included a thorough process to assure the accurate reconciliation and proper disposition of all drugs and biologicals necessary to meet the potential needs of the residents. As a result of this deficient practice, the safety and efficacy of Emergency Kit (E-Kit) medications and devices were compromised. This deficient practice had the potential to affect any patient who required immediate use of a medication or device in the E-Kit.	F 755	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were identified as being affected by the deficient practice. On 8/10/22, the expired E- kit was immediately removed. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	

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F 755	Continued From page 21 Findings include: On 08/09/22 at 02:57 PM, an inspection of the long-term care medication cart was done. In the bottom drawer of the cart, a sealed E-Kit (Emergency Kit) labeled COVID-19 EKIT EXPIRES: 9/30/21, was found. Labeling indicated that the E-Kit had been restocked in October 2020. The E-Kit inventory sheet attached to the sealed container listed the following contents: 2 - Aerochamber Plus Flow-Vu (a valved holding chamber that helps residents inhale metered dose inhaler medications correctly), with an expiration date of 09/21. 2 - Ventolin HFA 90 mcg (micrograms) Inhaler (used to prevent and treat wheezing and shortness of breath), with an expiration date of 12/21. 2 - 24-count Dexamethasone 2 mg (milligrams) Tablets (a steroid used to prevent the release of substances in the body that cause inflammation), with an expiration date of 09/21. On 08/09/22 at 03:26 PM, an interview was done in the Treatment/Activity Room with the Administrator and the Director of Nursing (DON). The Administrator stated the E-Kit was "for COVID only" and they never would have used it. Both the Administrator and DON confirmed that the facility Nurses are responsible to check the cart for outdated medications on a daily basis and that the facility Pharmacist should also be checking the cart every month. The Administrator agreed that someone should have pulled the expired E-Kit out and either sent it back to the	F 755	SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: No residents were identified as being affected by the deficient practice. On 8/10/22, all e-kits were inventoried and evaluated to ensure none were expired. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Every shift, the RN will perform an audit of all e-kits to ensure none are expired. This audit will be documented on their shift assignment record. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly the Charge Nurse will perform a validation audit of all e-kits to ensure none are expired. Results of the audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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	125023		08/11/2022

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F 755	Continued From page 22 Pharmacy or destroyed it.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to ensure a medication error rate of less than 5%, as evidenced by two medication errors observed out twenty-seven opportunities for errors, for an error rate of 7.41%. Safe and thorough medication administration practices are essential for the health and well-being of the residents. As a result of this deficient practice, one resident (Resident 4) was placed at risk of not receiving therapeutic doses of his psychiatric medications. This deficient practice has the potential to affect all residents in the facility receiving medications. Findings include: Resident (R)4 is a 90-year-old male admitted to the facility on 04/02/21. His diagnoses include failure to thrive, major depressive disorder, anxiety disorder, and dementia with behavioral disturbance. On 08/08/22 at 03:38 PM, a review of his Minimum Data Set (MDS) Quarterly Review Assessment with Assessment Reference Dates (ARD) of 04/11/22 and 07/11/22 noted that R4's	F 759	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: As of 8/12/22, medications for resident (R4) are no longer being mixed with the resident□s food. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: On 8/12/22, all residents reviewed to identify if medications are mixed with food. No other residents identified. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly, Pharmerica will provide medication pass audits and education to Nurse Staff.	9/1/22

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F 759	Continued From page 23 Brief Interview for Mental Status (BIMS) exams had evaluated him with a score of 14. A score of 13-15 indicates the interviewee is "cognitively intact." Both assessments also documented no acute changes in mental status. Further review of R4's medical record at this time revealed the following physician order from 12/06/21: "Start monitoring... 3. paranoid, e.g. thinking that someone is monitoring him and setting up cameras and bugs on some items in his room or wherever he's located ... someone must have added poison on his food or drink, hence prefers sealed bottled water and not to take medication." On 08/10/22 at 04:55 PM, an observation was done of Registered Nurse (RN)1 preparing to administer the following psychiatric medications to R4: Aripiprazole [an antipsychotic] 1mg/ml [milligram per milliliter] liquid, 2 mls [milliliters], may mix with food or drinks. Citalopram [an antidepressant] 10mg/5ml solution, 2.5 mls, may mix with food or drinks. After preparing the colorless liquids/solutions, observed RN1 pour both doses all over the main dish (chicken with a thin gravy) in R4's partitioned dinner plate. RN1 then handed the dinner tray to Certified Nurse Aide (CNA)4, who delivered the dinner tray to R4. Neither RN1 nor CNA4 informed R4 that there was medication in his food. When asked, RN1 stated that R4 could feed himself and that the medications were poured onto his food "because he thinks his medicine is a poison." RN1 then proceeded to	F 759	If it is required to mix medication into a resident□s food, the nurse will monitor the ingestion of the food to ensure the resident ingested the medication. This will be a specific care plan as well as it will be indicated on MAR as a reminder when administering medications. By 9/1/22 education provided to all nurses regarding medication administration. HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Monthly, the Charge Nurse will review for any residents receiving their medications in food. Of those, an audit will be performed to ensure there is a care plan for the nurse to monitor the ingestion of the food/medication and validate that the instructions are on the MAR. Results of the audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at the monthly QAPI meeting.	

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F 759	Continued From page 24 continue his afternoon medication pass, moving on to the next resident. On 08/10/22 at 05:11 PM, observed R4 inform the Director of Nursing (DON) that he was done with his dinner tray. The DON took R4's dinner tray from him and placed it on the meal cart to go back to the kitchen. An inspection of the dinner tray at this time noted all but one small piece of minced chicken was gone from the main dish section of the plate, however thin gravy still remained in the bottom of the partition. Despite it being impossible to determine how much of each medication R4 received (whether he accidently dropped some of the food, shared some of the food with another resident, diverted food into his napkin, or how much medication may or may not have been left in the plate), RN1 documented both medications as fully administered.	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		9/25/22

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F 880	Continued From page 25 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 26 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate protective and preventive measures for COVID-19 and other communicable diseases and infections, as evidenced by the facility failing to ensure staff followed standard precautions in relation to hand hygiene and glove use. As a result of this deficient practice, resident safety was compromised. This deficient practice has the potential to affect all residents in the facility. Findings include: On 08/08/22 at 12:15 PM observed (Registered Nurse)1 put on gloves, remove a wiping cloth from the container and wipe the top surface of the medication cart. RN1 removed the gloves and put on another pair of gloves. No hand hygiene was observed after glove removal and prior to putting on a new pair of gloves. On 08/08/22 at 12:19 PM, an observation of a gastric tube dressing change was done. During the process of Registered Nurse (RN)1 conducting the dressing change on Resident (R)10, observed RN1 change his gloves three times without any hand hygiene in between. When asked, RN1 acknowledged and apologized	F 880	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 8/12/22, immediate just in time education was provided to staff (RN1) regarding proper hand hygiene. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN: By 8/26/22, all care staff provided education on performing hand hygiene. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: By 9/25/22 as required by the directed plan of correction, all staff were educated on the following Centers for Disease Control (CDC) video modules:	

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F 880	Continued From page 27 that he did not perform hand hygiene in between changing gloves.	F 880	a) Clean Hands - https://youtu.be/xmYMUly7qiE b) Keep COVID-19 Out! - https://youtu.be/7srwrF9MGdw By 9/25/22, all staff received in person training by Director of Nursing, Administrator, Medical Director, or Infection Preventionist on: a) Module 6A: Principles of Standard Precautions b) Module 7: Hand Hygiene HOW THE CORRECTIVE ACTION WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR: Weekly, the Charge Nurse will perform observational audits for compliance to appropriate hand hygiene. Results of all weekly audits will be reviewed at the monthly QAPI meeting to ensure the corrective action is sustained. Ongoing validation by the Administrator at monthly QAPI meeting.	