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F 000	INITIAL COMMENTS A recertification survey was conducted by the Office of Health Care Assurance (OHCA) on 08/07/23 - 08/10/23. The facility was not in compliance with 42 CFR 483 Subpart B. Complaints (ACTS #10193, 10208, 10437, 10464) and Facility Reported Incident (ACTS #9760) were also investigated. ACTS 10193 and 10464 was substantiated. Survey Census: 172 Sample Size: 49	F 000		
F 550 SS=E	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.	F 550		

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

Electronically Signed

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F 550	Continued From page 1 §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 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 interview, and policy review, the facility failed to protect and promote quality of life for 4 of 5 residents sampled (Residents (R)29, 52, 75, and 1) by making sure that they were treated with respect and dignity. Specifically, the facility failed to ensure that English was consistently spoken in all resident care areas, exposing R1 to frustrating situations. R29 handling R29 roughly while providing care despite resident's request to be gentle. R52 and R75 both reported having to wait 30 minutes to 1 hour for staff to respond and/or acknowledge the resident after activating their call light. This deficient practice has the potential to affect all residents in the facility. Findings include: 1) On 08/07/23 at 11:43 AM, conducted an interview with R29 regarding staff treating the resident with respect and dignity. R29 reported there are some staff that are rough when they	F 550		

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clean her "down there" (providing peri care). R29 explained that she had surgery "down there" and I have to remind the staff more than once to be gentle. R29 reported that it is not very respectful when you have to keep reminding the same staff about it.

2) On 08/08/23 at 11:05 AM, conducted a telephone interview with R52's Family Member (FM)2. Inquired if FM2 had any concerns related to how long R52 must wait after activating her call light. FM2 reported having to wait approximately 30 minutes to 1 hour before have staff answer the call light. FM2 reported that they have had to wait while at the facility and there have been times when R52 called FM2 to tell her that she needs help. FM2 would then call the facility, then finally they would go and assist R52. FM2 stated that there have been times when she needed to be cleaned (after incontinence). Inquired if staff were visible when FM2 was in the facility and had to wait. FM2 confirmed he/she observed staff walking by the room but did not stop to see why the call light was activated.

3) On 08/09/23 at 08:25 AM, conducted an interview with Resident (R)75. During the interview, R75 reported having to wait 30 minutes to 1 hour for staff to respond to the resident's activated call light or acknowledge that they are aware the resident is waiting for staff to respond. R75 stated staff can be seen walking past his door, but do not stop to help him or tell him that they are busy and will be back to assist him. R75 stated "It makes me think that my call light is broken because no one comes in to check on me. So, when I press the call light, I don't let it go and keep pressing it until someone comes. I don't like that feeling."

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F 550	Continued From page 3 4) On 08/07/23 at 09:54 AM, an interview was done with Resident (R)1 at his bedside. R1 complained about the staff, specifically the certified nurse aides (CNAs), speaking Filipino around and over him. Stated that he hears the CNAs speaking Filipino to each other "all the time" and he does not like it. R1 explained that speaking a language other than English around him is upsetting because he cannot understand what they are saying, and feels that sometimes they are "talking bad about me." R1 stated that he has asked for the CNAs not to speak Filipino around him, and that he knows that "they shouldn't be doing that," but it continues. On 08/10/23 at 01:35 PM, a review of the facility Language Policy, effective 10/01/15, revealed the following: "Employees ... are to speak English when communicating with residents, visitors and other employees while working in resident care areas ..."	F 550		
F 558 SS=E	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to accommodate the needs of 3 of 5 residents sampled (Residents	F 558		

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(R)1, 74, and 100) by ensuring that their call lights were always placed within reach. As a result of this deficient practice, the residents were placed at risk of not having their needs identified and met in a timely manner. This deficient practice has the potential to affect all the residents at the facility who can activate a call light, or have it activated on their behalf.

Findings include:

1) Resident (R)1 is a 54-year-old male admitted to the facility on 08/12/14 for long-term care. R1's active diagnoses include but are not limited to quadriplegia (a form of paralysis that affects all four limbs, plus the torso), respiratory failure, and dependence on a respirator (ventilator) for breathing. A review of his most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/25/23 revealed that R1 was determined to have a Brief Interview for Mental Status (BIMS) score of 14, meaning he was found to be cognitively intact.

During an interview with R1 at his bedside on 08/07/23 at 09:54 AM, R1 stated that as long as his call light was positioned next to his head properly, he could activate it. Observation was done of R1's call light clipped to his pillow and positioned to the left of his head.

On 08/07/23 at 11:31 AM, concurrent observation and interview was done with R1 at his bedside. Observation was made that R1's call light was not in position next to his head. Surveyor asked R1 where his call light was. R1 responded that he did not know. Surveyor exited room and asked the ward clerk to find a certified nurse aide (CNA) to assist R1, as he had requested assistance in

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getting him something to drink. At 11:50 AM, CNA5 entered the room. When asked to locate R1's call light, it took her several minutes to locate the call light which had been left on the headboard of the bed. CNA5 explained that she and another CNA had given R1 a bed bath this morning, and that someone must have forgotten to put the call light back. CNA5 agreed that it was important that R1's call light always be positioned where he could reach it.

On 08/10/23 at 10:46 AM, observed R1 sitting up in a wheelchair in his room. R1 was very upset, stating that he had wanted to go to activities but that he had been forgotten, and now it was too late. Observed R1's call light placed on a shelf well out of his reach. At his request, Surveyor pressed the call light on R1's behalf. CNA6 responded to the call light and confirmed that the call light should have been clipped to R1's pillow before the staff who had gotten him up to the wheelchair left the room.

2) R74 is a 69-year-old male admitted to the facility on 09/07/21 for long-term care. R74's active diagnoses include but are not limited to chronic respiratory failure, and dependence on a respirator (ventilator) for breathing. A review of his most recent MDS assessment, with an ARD of 07/05/23 revealed that R74 was determined to have a BIMS score of 15, meaning he was found to be cognitively intact. R74 could not speak and therefore communicated through writing on notepaper, and using hand signals.

On 08/08/23 at 09:06 AM, R74 indicated through gestures and writing that he needed his call light to call for help. Observation was made that his call light was not on his bed. Surveyor looked for

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F 558	Continued From page 6 his call light to assist him and found it hanging off the left side of the bed on the floor where he could neither see nor reach it. After handing the call light to R74, he immediately pressed the button repeatedly. Observation done of R74 with labored breathing, and the use of accessory muscles. Surveyor asked if he needed tracheal suctioning, R74 nodded yes. At 09:13 AM, after receiving no response to his call light, Surveyor left the room and located a staff member who quickly assisted him. 3) R100 is a 56-year-old male admitted to the facility on 07/30/20 for long-term care. R100's active diagnoses include but are not limited to functional quadriplegia and chronic respiratory failure, with a status of being confined to the bed. Although not on his active diagnosis list, R100 was also dependent on a ventilator for breathing. On 08/07/23 at 09:08 AM, one of the observations made at the bedside of R100 was that his call light was nowhere to be found. Surveyor exited the room to find a staff member. At 09:16 AM, Registered Nurse (RN)5 entered the room with the Surveyor. RN5 was able to locate R100's call light hanging off of the left side of his bed. RN5 acknowledged that although R100 could not activate his call light because he could neither move his head nor limbs, it was important that his call light was always visible and within reach. RN5 agreed that the call light could be activated by a visitor should R100 need assistance.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F 561		

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F 561	Continued From page 7 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. §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 interview and record review (RR), the facility failed to identify and support 2 of 2 residents sampled (Residents (R)1 and 65) preference to be gotten up out of bed daily. As a result of this deficient practice, these residents did not have their needs met and were placed at risk of not attaining their highest practicable well-being. This deficient practice has the potential to affect all the residents at the facility.	F 561		

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F 561	Continued From page 8 Findings include: 1) Resident (R)1 is a 54-year-old male admitted to the facility on 08/12/14 for long-term care. R1's active diagnoses include but are not limited to quadriplegia (a form of paralysis that affects all four limbs, plus the torso), respiratory failure, and dependence on a respirator (ventilator) for breathing. A review of his most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 05/25/23 revealed that R1 was determined to have a Brief Interview for Mental Status (BIMS) score of 14, meaning he was found to be cognitively intact. During an interview with R1 at his bedside on 08/07/23 at 09:54 AM, R1 reported that he likes to be gotten up daily to a wheelchair, sometimes to go to activities, and other times just to get out of bed and sit in the common area. R1 complained that the facility used to get him up out of bed all the time, but now has not been up to a wheelchair "for a long time." R1 stated his belief that he has not been gotten out of bed because the facility is short-staffed. R1 explained that he needed two staff members and a mechanical lift (assistive device that enables the movement, transfer, and positioning of an immobilized resident to and from a sitting and/or lying position) to be transferred, so when the facility is short-staffed, he usually does not get transferred. On 08/10/23 at 10:46 AM, observed R1 had been transferred from bed to a wheelchair for the first time during the survey period. When asked, R1 confirmed that this is the first time "in a while" that the facility assisted him out of bed. On 08/10/23 at 12:00 PM, reviewed a	F 561		

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Point-of-Care (POC) report documenting the facility getting R1 out of bed for the months of June, July, and August. The report displayed that R1 had consistently been gotten out of bed 2-3 times a day since June, including during the survey period. There was no documentation that R1 had been offered and refused to get up on the report.

On 08/10/23 at 12:45 PM, an interview was done with R1 in the common area. After reviewing the POC report with him, R1 emphatically denied that he had been gotten out of bed daily for months. R1 reported that he could not remember the last time he had gotten up out of bed prior to this morning. When asked if perhaps the facility had offered to get him up, and he had refused, R1 responded "no."

2) R65 is a 63-year-old male admitted to the facility on 12/15/17 for long-term care. R65's active diagnoses include but are not limited to amyotrophic lateral sclerosis (ALS; a progressive nervous system disease that weakens muscles and impacts physical function), major depressive disorder, chronic respiratory failure, and dependence on a respirator (ventilator) for breathing. A review of his most recent MDS assessment, with an ARD of 06/02/23 revealed that R65 was determined to have a BIMS score of 13, meaning he was found to be cognitively intact. R65 could not speak and therefore communicated through facial expressions and mouthing words.

On 08/07/23 at 09:18 AM, during an interview with R65 at his bedside, he was able to communicate that he is supposed to get up out of bed to his wheelchair every day. R65 indicated

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that he did not know/could not recall when he was last transferred out of bed. Observations were done at this time that his special wheelchair and a mechanical lift were kept at his bedside. R65 indicated that both were stored there at the bedside but confirmed again that they had not been used for a long time.

On 08/10/23 at 09:51 AM, during a review of R65's comprehensive care plan, it was noted that there is a resident-centered care plan initiated in 2017 and last revised on 05/28/20 specifically focused on R65's desire to be gotten up out of bed. The care plan focus: "Resident wants to be out of bed qd [every day]." The care plan goal: "Resident will be on wheelchair before lunch until [sic] qd."

On 08/10/23 at 12:10 PM, reviewed a POC report documenting the facility getting R65 out of bed for the months of June, July, and August. The report displayed that R65 had consistently been gotten out of bed 2-3 times daily on most days since June, including during the survey period. There was no documentation that R65 had been offered and refused to get up on the report.

On 08/10/23 at 12:50 PM, an interview was done with R65 at his bedside. After reviewing the POC report with him and asking if that sounded accurate, R65 denied that he had been gotten out of bed daily for months. When asked if perhaps the facility had been offering to get him up on a daily basis, R65 indicated no by moving his lower jaw from side to side.

On 08/10/23 at 12:55 PM, an interview was done with Unit Manager (UM)3 in her office. When asked about the POC report documenting both

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F 561	Continued From page 11 residents being gotten up out of bed daily and how the documentation did not align with either resident interviews or Surveyor observations, UM3 could not explain the inconsistencies, stating, "I don't know what to tell you."	F 561		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584		

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F 584	Continued From page 12 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to provide a safe, homelike environment for one out of 49 residents sampled (Resident (R) 88). This deficient practice has a negative effect on resident's quality of life and places her at risk for psychosocial harm. Findings Include: R88 is a 78-year-old female admitted to the facility on 07/16/21. Observation and interview were conducted on 08/07/23 at 02:11 PM. R88 stated, "My neighbor's snacks are all over the place. I don't like seeing it all! The curtains need to be washed. It has not been washed since I have been here. It smells bad." An observation was made on a tear in the curtain that created a 5inch-by-5inch hole. To the right of R88's television are shelves, tables, large plastic storage bins, and stackable trays. These items contained food, packing boxes, plants, pillows, blankets, paper goods, and drinks. The items are stacked on top of one another creating a 5-foot-high pile. Some of the bins are overflowing with items that could potentially fall. Interview was conducted with the facility's	F 584		

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F 584	Continued From page 13 Housekeeping Manager (HM) on 08/09/23 at 09:01 AM in R88's room. HM stated that curtains are usually washed every three months and the tears in the curtains are usually hemmed. HM added that his department is currently in the process of evaluating all the curtains in the facility. Interview and observation were conducted on 08/10/23 at 08:17 AM in R88's room. R88 stated that she hasn't been out of her room because her roommate's belongings make it difficult for wheelchair access. This surveyor attempted to maneuver R88's wheelchair into the hallway. A shelf filled with food items and plants was obstructing the path into the hallway. R88's wheelchair did not fit in the opening between R88's bed and her roommate's shelf. Assistant Director of Nursing (ADON) 2 was summoned into R88's room. ADON2 was shown the tight pathway between R88's bed and the shelves. ADON2 also observed the shelves that were stacked over 5 feet high with various items. ADON2 agreed that the items and the shelves are possible safety hazards for individuals passing by. ADON2 also mentioned that R88's roommate's belongings were encroaching into R88's space and obstructed wheelchair accessibility.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		

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F 600	Continued From page 14 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 interviews and record review, the facility failed to protect Resident (R)52 from physical harm. Facility Staff (FS)7 confirmed pulling R52's right arm to repositioned in bed, no other staff were present at the time. Immediately after pulling R52's arm the resident reported pain and swelling to his/her right shoulder as a result of the incident. R52 was assessed by nursing staff which also noted redness to the resident's right shoulder. X-ray results confirmed R52 sustained a subluxation (partial dislocation) of the right (R) shoulder. R52 experienced pain and a decline in the resident's mobility ability which affected the resident's ability to achieve and maintain her highest level of physical well-being and had a decline in functional status. All residents requiring staff assistance for repositioning are at risk of this type of unintentional abuse if residents are not handled in a safe manner to prevent injury. Findings include: (Cross Reference to F609 Reporting an Allegation on Abuse/Neglect/Misappropriation; F610 Conducting a Thorough Investigation; and F676 Maintain Abilities)	F 600		

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F 600	Continued From page 15 The definition of "Willful" as defined at 485.5 in the definition of "abuse" and "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." The definition of "Abuse" as defined at 483.5 as "the willful infliction of injury....with resulting physical harm, pain, or mental anguish...." Review of a Facility Reported Incident (FRI) in the Aspen Complaints/Incidents Tracking System (ACTS) #10193 initial report was reported to the State Agency (SA) on 03/30/23 at 01:35 PM via email, "Resident was being repositioned in bed by staff CNA (FS)4. Staff pulled on resident's arm to straighten her position in the bed and resident reported pain in the rt (right) shoulder. X-ray ordered, report received 3/29/23 and x-ray shows subluxation of Rt shoulder with chronic rotator cuff tear, advanced osteopenia, and mild osteoarthritis of the AC joint. Ortho consult ordered, ortho unable to accommodate in person timely appointment, resident sent to ER for treatment on 3/30/23. Investigation was initiated. The facility's completed report for ACT#10193 was reported to the SA via email on 04/04/23 documented, "..... On 3/28/23 Resident was being repositioned in bed by staff CNA. Staff pulled on the resident's arm to straighten her position in the bed and resident reported pain in the rt shoulder. A portable X-ray was obtained, and the facility received the report on 3/29/23 which shows a subluxation of resident's Rt shoulder...." and " Abuse or neglect was ruled out." Facility provided re-education of staff member regarding using a draw sheet and 2 person assist for repositioning resident. 1:1 education provided. Staff has verbalized	F 600		

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understanding of need to use draw sheet and 2-person assist. Upon follow up she has returned demonstration of appropriate method of transfer.

On 08/08/23 at 11:05 AM, conducted an interview with R52's Family Member (FM)2 via telephone regarding the incident. FM2 reported he/she was aware of the incident and prior to FS7 pulling on the resident's arm to reposition the resident, R52 was walking and there was a possibility that the resident would be able to leave the facility. But since the incident, R52's ability to walk has been affected and stated that R52 has reported pain to him/her. R52 had used a walker for assistance but due to pain, loss of strength, loss of the ability to raise his/her arm above the head, or bear weight with the right (R) shoulder R52 has not been able to walk and is not receiving services to help the resident regain mobility. FM2 reported R52 has not walked since the incident and is concerned that R52's issues is not being properly addressed.

Observations of R52 conducted throughout the survey (08/07/23 at 09:28 am, 10:45 AM, 12:07 PM, 01:45 PM; 08/08/23 at 08:35 AM, 09:20 AM, 10:15 AM, 12:45 PM, and 02:15 PM; 08/09/23 at 08:00 AM, 08:53 AM, 12:12 PM, and 01:17 PM; and 08/10/23 at 09:00 AM and 10:35 AM) observed R52 lying in bed on his/her back. Resident was alert and orientated to person, place, time, and situation. During the observation on 08/10/23 at 09:00 AM, R52 reported that FS7 pulled on her arm to reposition the resident and immediately felt pain and was unable to move his/her arm. R52 then called FM2, who in turn called the unit nursing station and reported the incident to nursing staff. R52 stated the facility did an x-ray that day then 2 days later he/she

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went to the hospital because the doctor appointment was too far away. R52 confirmed that since the incident the resident has not been able to lift his/her right arm and has not walked because he/she cannot use a walker. R52 then attempted to lift the right arm and stopped immediately due to pain, observed R52 tightly squeezed both eyes shut and wince in pain and observed that the resident was not able to lift his/her right arm off the bed. Inquired with R52 if the resident had received rehab therapy since the incident to help regain functioning. R52 confirmed that although he/she would like to have therapy the resident has not received services for the partial dislocation. Inquired if the resident has pain related to the injury. R52 confirmed having pain.

On 08/10/23 at 12:40 PM, conducted a concurrent interview and record review of R52's Electronic Health Record (EHR) with the Director of Rehab Services. DRS reviewed R52's EHR and stated R52 is currently not receiving services, the facility had requested for approval for rehab services with the resident's insurance, but the request was denied. Inquired if R52 was referred for restorative services. Review of records documented on 01/03/23, R52 sustained an acute distal fracture of the right wrist and an x-ray report of the right shoulder documented " There is no radiographic evidence of acute fracture or dislocation. The humeral head and neck as well as the clavicle and scapula are intact. Visualized lung and parenchyma is clear. The bony mineralization is mildly decreased. Mild narrowing of Gleno-hemeral joint space and AC joint." DRS was unaware that R52 has sustained a right wrist fracture and further confirmed that staff should not have been pulling on the resident's arm to

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reposition the resident. DRS reviewed a physical therapy progress note, on 02/01/23, which documented R52 had been walking up to 100 feet with minimal to no assistance prior to the partial dislocation of the resident's right shoulder. Reviewed all x-ray results (from 01/03/23, 02/28/23, and 02/30/23) DRS confirmed the impression of the presence of a chronic rotator cuff tear was not documented on the 01/03/23 and the impression of injury or chronic injury to R52's right shoulder was only documented after FS7 pulled on R52's arm resulting a partial right shoulder dislocation which can go back into place without interventions.

On 08/10/23 at 01:29 PM, conducted an interview with the Administrator, Assistant Administrator (AA), and the Director of Nursing (DON) regarding FRI #10193. The DON confirmed she had conducted the investigation for the incident and abuse was not substantiated because when FS7 pulled R52's arm he/she did not intend to hurt the resident. This surveyor reviewed the definition of willful and abuse the Administrator, AA, and DON further explaining that although FS7 stated he/she did not pull R52's arm to hurt the resident, but FS7 did know that by pulling on R52's arm the resident could be injured and knowing this and not by not adhering to the professional standard of practice, still chose to pull the resident's arm to reposition. After further clarifying the definition of "willful" the Administrator and DON confirmed understanding that the intent of the action does not negate knowing the potential outcome could result in harm and still affect other residents. The DON stated that the facility did not identify the incident as abuse because the staff involved in the incident was apologetic about the incident and did

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F 600	Continued From page 19 not intentionally hurt the resident. As a result of not identifying the incident as abuse, the facility did not remove the staff from the floor to ensure knowledge and teaching of the professional standard of practice for repositioning residents would be implemented and did not meet the timeframe of reporting or completing a thorough investigation within two hours.	F 600		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive	F 604		

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F 604	Continued From page 20 alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to document ongoing re-evaluation of the need for restraints for one out of four residents sampled (Resident (R) 429). This deficient practice places the resident at risk for psychosocial harm. Findings Include: R429 is a 64-year-old male admitted to the facility on 07/31/23. Observations were conducted at various times between the dates 08/07/23-08/10/23. R429 had his mitten restraint on throughout the four-day span. Interview was conducted with Registered Nurse (RN) 25 on 08/09/23 at 01:34 PM near the nurse's station. RN25 stated that R429's mitten is supposed to be released every two hours. RN also mentioned that she only completes the flowsheet and has not charted in the progress notes regarding R429's restraint use. Interview was conducted with Unit Manager (UM) 3 on 08/09/24 at 02:58 PM. UM3 stated that charting in the progress notes should be done every shift especially regarding restraints. After reviewing R429's Electronic Health Record (EHR), UM3 concluded that the use of restraint and assessment was not being charted in the progress notes every shift.	F 604		

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F 604	Continued From page 21 A review of R429's EHR indicated an order for restraints that was started on 08/01/23. The order stated, "mitten to L [Left] hand to prevent resident from pulling out tracheostomy. Release every hours and assess for CMS [Circulatory Motor Sensory] and skin breakdown. Chart in progress note every shift. Every 2 hours." A review of R429's EHR indicated that charting of R429's restraint use was completed only during two shifts for four consecutive days (12 shifts total) between the dates of 08/05/23-08/08/23.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		

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F 609	Continued From page 22 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to report one reportable event of suspected resident (Resident (R)52) abuse event to the State Agency (SA) and Adult Protective Services (APS) within 2 hours of the incident if serious bodily injury is present, as mandated by state law. On 03/28/23 it was reported to the facility that R52 had an injury to the right shoulder which was red, swollen, and could not move his/her arm. R52 was allegedly abuse by Facility Staff (FS)4. As a result of this deficient practice the SA did not have information to determine if an investigation by their agency was needed, and there is the potential incidents are not thoroughly investigated, putting all residents of potential abuse at risk. Findings include: (Cross Reference to F600 Allegation of Abuse; F610 Conducting a Thorough Investigation; and F676 Maintain Abilities) The definition of "Willful" as defined at 485.5 in the definition of "abuse" and "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." The definition of "Abuse" as defined at 483.5 as "the willful infliction of injury....with resulting physical harm, pain, or mental anguish...."	F 609		

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F 609	Continued From page 23 Review of a Facility Reported Incident (FRI) in the Aspen Complaints/Incidents Tracking System (ACTS) #10193 initial report was reported to the State Agency (SA) on 03/30/23 at 01:35 PM via email, "Resident was being repositioned in bed by staff CNA (FS)4. Staff pulled on resident's arm to straighten her position in the bed and resident reported pain in the rt (right) shoulder. X-ray ordered, report received 3/29/23 and x-ray shows subluxation of Rt shoulder with chronic rotator cuff tear, advanced osteopenia, and mild osteoarthritis of the AC joint. Ortho consult ordered, ortho unable to accommodate in person timely appointment, resident sent to ER for treatment on 3/30/23. Investigation was initiated. The facility's completed report for ACT#10193 was reported to the SA via email on 04/04/23 documented, "..... On 3/28/23 Resident was being repositioned in bed by staff CNA. Staff pulled on the resident's arm to straighten her position in the bed and resident reported pain in the rt shoulder. A portable X-ray was obtained, and the facility received the report on 3/29/23 which shows a subluxation of resident's Rt shoulder...." and " Abuse or neglect was ruled out." Facility provided re-education of staff member regarding using a draw sheet and 2 person assist for repositioning resident. 1:1 education provided. Staff has verbalized understanding of need to use draw sheet and 2-person assist. Upon follow up she has returned demonstration of appropriate method of transfer. On 08/10/23 at 01:29 PM, conducted an interview with the Administrator, Assistant Administrator (AA), and the Director of Nursing (DON) regarding FRI #10193. The DON confirmed she had conducted the investigation for the incident	F 609		

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F 609	Continued From page 24 and abuse was not substantiated because when FS7 pulled R52's arm he/she did not intend to hurt the resident. This surveyor reviewed the definition of willful and abuse the Administrator, AA, and DON further explaining that although FS7 stated he/she did not pull R52's arm to hurt the resident, but FS7 did know that by pulling on R52's arm the resident could be injured and knowing this and not by not adhering to the professional standard of practice, still chose to pull the resident's arm to reposition. After further clarifying the definition of "willful" the Administrator and DON confirmed understanding that the intent of the action does not negate knowing the potential outcome could result in harm and still affect other residents. The DON stated that the facility did not identify the incident as abuse because the staff involved in the incident was apologetic about the incident and did not intentionally hurt the resident. As a result of not identifying the incident as abuse, the facility did not remove the staff from the floor to ensure knowledge and teaching of the professional standard of practice for repositioning residents would be implemented and did not meet the timeframe of reporting or completing a thorough investigation within two hours.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		

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F 610	Continued From page 25 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure further potential for abuse was prevented and a completed report was submitted to the State Agency (SA) within 5 days of the incident. Facility Staff (FS)7 partially dislocated Resident (R)52's right (R) shoulder while attempting to reposition the resident. Applying the federal and state definitions of willful and abuse, the SA found the facility to not be in compliance with regulations and identified the incident as abuse. The facility did not identify the incident as abuse and therefore did not remove the staff from providing care and submitted the completed report 6 days after the incident. Findings include: (Cross Reference to F609 Reporting an Allegation on Abuse/Neglect/Misappropriation; F610 Conducting a Thorough Investigation; and F676 Maintain Abilities) The definition of "Willful" as defined at 485.5 in the definition of "abuse" and "means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." The definition of "Abuse" as defined at	F 610		

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	125019	A. BUILDING _____ B. WING _____	08/10/2023

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F 610	Continued From page 26 483.5 as "the willful infliction of injury.... with resulting physical harm, pain, or mental anguish...." Review of a Facility Reported Incident (FRI) in the Aspen Complaints/Incidents Tracking System (ACTS) #10193 initial report was reported to the State Agency (SA) on 03/30/23 at 01:35 PM via email, "Resident was being repositioned in bed by staff CNA (FS)4. Staff pulled on resident's arm to straighten her position in the bed and resident reported pain in the rt (right) shoulder. X-ray ordered, report received 3/29/23 and x-ray shows subluxation of Rt shoulder..." The facility's completed report for ACT#10193 was reported to the SA via email on 04/04/23. Although the completed report documented training was completed with facility Staff FS7 there is no indication of when the training was completed. Facility provided re-education of staff member regarding using a draw sheet and 2 person-assist for repositioning resident. 1:1 education provided. Staff has verbalized understanding of need to use draw sheet and 2-person assist. Upon follow up she has returned demonstration of appropriate method of transfer. On 08/10/23 at 01:29 PM, conducted an interview with the Administrator, Assistant Administrator (AA), and the Director of Nursing (DON) regarding FRI #10193. The DON confirmed she had conducted the investigation for the incident and abuse was not substantiated because when FS7 pulled R52's arm he/she did not intend to hurt the resident. This surveyor reviewed the definition of willful and abuse the Administrator, AA, and DON further explaining that although FS7 stated he/she did not pull R52's arm to hurt the resident, but FS7 did know that by pulling on	F 610		

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F 610	Continued From page 27 R52's arm the resident could be injured and knowing this and not by not adhering to the professional standard of practice, still chose to pull the resident's arm to reposition. After further clarifying the definition of "willful" the Administrator and DON confirmed understanding that the intent of the action does not negate knowing the potential outcome could result in harm and still affect other residents. The DON stated that the facility did not identify the incident as abuse because the staff involved in the incident was apologetic about the incident and did not intentionally hurt the resident. As a result of not identifying the incident as abuse, the facility did not remove the staff from the floor to ensure knowledge and teaching of the professional standard of practice for repositioning residents would be implemented and did not meet the timeframe of reporting or completing a thorough investigation within two hours.	F 610		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;	F 622		

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F 622	Continued From page 28 (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)	F 622		

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F 622	Continued From page 29 (i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to properly document a transfer summary to be received by an acute care provider for one resident (R), R378, out of a sample of two residents. This deficient practice fails to inform the receiving acute care provider of the care needed by the resident and does not allow R378 a smooth transfer to the acute care	F 622		

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F 622	Continued From page 30 provider from the facility. Finding includes: Record review of R378's electronic health record (EHR). Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/05/22 revealed that R378 was admitted to the facility on 08/31/22 from a hospital. R378 had the following medical diagnoses: irregular heart rate, heart failure (a weakened heart that cannot supply the body with enough oxygen), an active cancer of a type of white blood cells (WBCs) that produce antibodies to help the body fight off infections, an anemia (low blood cell count) where the bone marrow cannot produce new WBCs, red blood cells (RBCs, provides oxygen to all cells in the body), and platelets (helps to clot and stop bleeding). R378 received chemotherapy and transfusions while hospitalized. Read the discharge summary from the hospital filed on 08/31/22 at 08:44 AM. R378's physician agreed to hold R38's cancer treatment while R378 received short-term rehabilitation (STR) at the long term care facility. Review of progress notes revealed that R378 required a blood transfusion on 10/17/22 and was transferred to an acute care provide to receive the blood transfusion. "Nutrition/Dietary Note" dated 10/19/22 and 11/21/22 documented by the Registered Dietitian (RD) revealed that R378 progressively lost weight and documented on 12/05/22, R378 was refusing to eat and had continued nausea with vomiting despite the use of an antiemetic (medication used to treat nausea and vomiting). Read "SBAR [situation, background, action, and response]" progress note documented on 12/06/22 at 11:45 AM. It stated that R378 was to be transferred to the hospital for R378's complaints of weakness	F 622		

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F 622	Continued From page 31 and needed further evaluation and treatment of low blood pressure. Reviewed "[facility name] Discharge Summary" with discharge date of 12/06/22 documented by R378's medical doctor (MD)1. It lacked communication regarding to the specific needs R378 required from the hospital that could not be met at the facility and the facility's efforts to meet those specific needs. On 08/10/23 at 10:39 AM, conducted a phone interview with R378's medical doctor (MD)1. MD1 agreed that the transfer summary documented by him could be written better. On 08/10/23 at 11:25 AM, conducted a concurrent review of R378's "[facility name] Discharge Summary" with discharge date of 12/06/22 and interview with Unit Manager (UM)1 in UM1's office. UM1 stated that the document was unacceptable and that it needs to "paint a picture" of the resident. The transfer document should specifically identify R378's required need(s) that can be given by the hospital and care given by the facility to try and meet those need(s), but were unsuccessful.	F 622		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		

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F 657	Continued From page 32 (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 interview and record review, the facility failed to ensure the timely review and revision of the Resident's Comprehensive Care Plan (CP) included his family representative/healthcare surrogate for 1 of 3 residents (Resident (R)84) in the sample. As a result of this deficient practice, staff did not have all the information necessary to effectively address the resident's status, condition, and/or needs adequately so that he could meet his highest potential of physical and psychosocial well-being. This deficient practice has the potential to affect all the residents at the facility. Findings include: Resident (R)84 is a 32-year-old male admitted to the facility on 12/11/18 for long-term care. R84's active diagnoses include but are not limited to a personal history of traumatic brain injury, chronic	F 657		

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respiratory failure, and functional quadriplegia (a form of paralysis that affects all four limbs, plus the torso). R84 does not speak and is incapable of voluntary movement of his limbs or head. In addition, R84 does not reliably/consistently respond to verbal stimuli, so cannot be assessed for cognitive status.

On 08/07/23 at 01:50 PM, a phone interview was done with R84's family representative/healthcare surrogate (FR). FR reported that she is very involved with R84's care, visits him daily, and keeps careful notes of all care planning meetings, but had not been invited to one for more than 4 months. Documentation of the last 6 months of Multidisciplinary Care Conference meetings, including the sign-in sheets, was requested from the facility.

On 08/09/23 at 01:30 PM, an interview was done with the Director of Social Services (MSW) in the Conference Room as she delivered documentation of the last 2 Multidisciplinary Care Conference meetings, recorded on 04/14/23 and 07/14/23. MSW stated that through her research, she could not find evidence that FR had been invited to either April or July's Care Conference meetings. MSW also confirmed that she could not find sign-in sheets for either meeting. Reviewing the documentation, MSW reported that it did look like FR had not been invited to the last 2 meetings. When specifically asked if she thought the meetings had occurred, MSW responded that the documentation did not support that the meetings took place. MSW reported that the Social Services Assistant responsible for the 2 meetings had left the facility in July. MSW had reached out to her to ask what had happened with the Care Conferences and documentation,

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F 657	Continued From page 34 but had not received a call back yet. At the time of survey exit, the facility was unable to provide any new information regarding the Care Conference meetings.	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		

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F 676	Continued From page 35 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide the necessary care and services to ensure two residents' abilities in activities of daily living are not diminished. Facility Staff (FS)7 repositioned R52 by pulling the resident's arm resulting in a subluxation (partial dislocation) of the resident's right (R) shoulder. Prior to the incident, R52 could walk approximately 100 feet with minimal assistance and was in the process of finding appropriate discharge placement after the incident the resident is unable to walk and is not receiving restorative services to help maintain his/her strength to walk. As a result of this deficient practice, all residents needing restorative services are at a for potential risk of harm. Findings include: (Cross Reference to F600 Allegation of Abuse; F609 Reporting an Allegation on Abuse/Neglect/Misappropriation; and F610 Conducting a Thorough Investigation) The facility's completed report for ACT#10193 was reported to the SA via email on 04/04/23 documented, "..... On 3/28/23 Resident was being repositioned in bed by staff CNA. Staff pulled on the resident's arm to straighten her position in the bed and resident reported pain in the rt shoulder. A portable X-ray was obtained,	F 676		

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and the facility received the report on 3/29/23 which shows a subluxation of resident's Rt shoulder...."

On 08/08/23 at 11:05 AM, conducted an interview with R52's Family Member (FM)2 via telephone regarding the incident. FM2 reported he/she was aware of the incident and prior to FS7 pulling on the resident's arm to reposition the resident, R52 was walking and there was a possibility that the resident would be able to leave the facility. But since the incident, R52's ability to walk has been affected and stated that R52 has reported pain to him/her. R52 had used a walker for assistance but due to pain, loss of strength, loss of the ability to raise his/her arm above the head, or bear weight with the right (R) shoulder R52 has not been able to walk and is not receiving services to help the resident regain mobility. FM2 reported R52 has not walked since the incident and is concerned that R52's issues is not being properly addressed.

Observations of R52 conducted throughout the survey (08/07/23 at 09:28 am, 10:45 AM, 12:07 PM, 01:45 PM; 08/08/23 at 08:35 AM, 09:20 AM, 10:15 AM, 12:45 PM, and 02:15 PM; 08/09/23 at 08:00 AM, 08:53 AM, 12:12 PM, and 01:17 PM; and 08/10/23 at 09:00 AM and 10:35 AM) observed R52 lying in bed on his/her back. Resident was alert and orientated to person, place, time, and situation. During the observation on 08/10/23 at 09:00 AM, R52 reported that FS7 pulled on her arm to reposition the resident and immediately felt pain and was unable to move his/her arm. R52 then called FM2, who in turn called the unit nursing station and reported the incident to nursing staff. R52 stated the facility did an x-ray that day then 2 days later he/she

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went to the hospital because the doctor appointment was too far away. R52 confirmed that since the incident the resident has not been able to lift his/her right arm and has not walked because he/she cannot use a walker. R52 then attempted to lift the right arm and stopped immediately due to pain, observed R52 tightly squeezed both eyes shut and wince in pain and observed that the resident was not able to lift his/her right arm off the bed. Inquired with R52 if the resident had received rehab therapy since the incident to help regain functioning. R52 confirmed that although he/she would like to have therapy the resident has not received services for the partial dislocation. Inquired if the resident has pain related to the injury. R52 confirmed having pain.

Review of the resident's two most recent quarterly Minimum Data Set (MDS) with ARDs of 03/20/23 (MDS1) and 06/13/23(MDS)2 documented MDS1 was completed prior to R52 incurring the partial dislocation of the right shoulder and MDS2 was after the injury. Review of Section C. Cognitive Function a Brief Interview of Mental Status (BIMS) score was 13 indicating the resident is cognitively intact. Review of Section G. Functional Status documented in MDS R52 walked in the room and corridor with limited assistance (resident highly involved, staff provided guided maneuvering of limbs or other non-weight bearing support). Review of MDS2 documented Section C. documented a BIMS score of 14 indicating the resident is cognitively intact. Review of Section G. Functional Status documented R52 did not walk in the room or corridor.

Review of R52's Electronic Health Record (EHR) documented on a nursing progress note on

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F 676	Continued From page 38 3/29/2023 03:41 PM, R52's physician reviewed thex-ray results of R shoulder and R humerus and confirmed the subluxation of the right humeral head. A progress note on 04/05/23 at 12:53 documented after returning from an orthopedic appointment, there was a new order for physical therapy and occupational therapy to the right shoulder. Review of physician orders documented an order for "OT clarification order: Skilled OT services 3x/week x 8 weeks for self-care training, therapeutic exercise, therapeutic activities, neuromuscular reeducation, and group therapy No directions specified for order" on 05/17/2023. Review of Nursing rehab and Restorative Nursing Administration Record documented in August 2023; Active Range of Motion (ROM) for was completed only once, and No documentation that the resident recieved restorative AROM exercise to BUE/BLE (bilaterlateral upper extremities/ bilateralteral lower extremities) or walking program #2 RNA to ambulate resident using a FWWto ambulate up to 100 feet with wheelchair to follow for safety for 15 minuties 6 times a week did not occur. Review of R52's two most recent Minimium Data Set Assessments 03/20/23 section G. Functional Abilities for walking On 08/10/23 at 12:40 PM, conducted a concurrent interview and record review of R52's EHR with the Director of Rehab Services. DRS reviewed R52's EHR and stated R52 is currently not receiving services, the facility had requested for approval for rehab services with the resident's insurance, but the request was denied. Inquired if R52 was referred for restorative services. Review of records documented on 01/03/23, R52 sustained an acute distal fracture of the right wrist and an x-ray report of the right shoulder	F 676		

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F 676	Continued From page 39	F 676		

documented " There is no radiographic evidence of acute fracture or dislocation. The humeral head and neck as well as the clavicle and scapula are intact. Visualized lung and parenchyma is clear. The bony mineralization is mildly decreased. Mild narrowing of Gleno-hemeral joint space and AC joint." DRS was unaware that R52 has sustained a right wrist fracture and further confirmed that staff should not have been pulling on the resident's arm to reposition the resident. DRS reviewed a physical therapy progress note, on 02/01/23, which documented R52 had been walking up to 100 feet with minimal to no assistance prior to the partial dislocation of the resident's right shoulder. Reviewed all x-ray results (from 01/03/23, 02/28/23, and 02/30/23) DRS confirmed the impression of the presence of a chronic rotator cuff tear was not documented on the 01/03/23 and the impression of injury or chronic injury to R52's right shoulder was only documented after FS7 pulled on R52's arm resulting a partial right shoulder dislocation which can go back into place without interventions.

On 08/10/23 at 01:29 PM, conducted an interview with the Administrator, Assistant Administrator (AA), and the Director of Nursing (DON) regarding FRI #10193. The DON confirmed she had conducted the investigation for the incident and abuse was not substantiated because when FS7 pulled R52's arm he/she did not intend to hurt the resident. This surveyor reviewed the definition of willful and abuse the Administrator, AA, and DON further explaining that although FS7 stated he/she did not pull R52's arm to hurt the resident, but FS7 did know that by pulling on R52's arm the resident could be injured and knowing this and not by not adhering to the

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F 676	Continued From page 40 professional standard of practice, still chose to pull the resident's arm to reposition. After further clarifying the definition of "willful" the Administrator and DON confirmed understanding that the intent of the action does not negate knowing the potential outcome could result in harm and still affect other residents. The DON stated that the facility did not identify the incident as abuse because the staff involved in the incident was apologetic about the incident and did not intentionally hurt the resident. As a result of not identifying the incident as abuse, the facility did not remove the staff from the floor to ensure knowledge and teaching of the professional standard of practice for repositioning residents would be implemented and did not meet the timeframe of reporting or completing a thorough investigation within two hours.	F 676		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide the required care and needed treatment for one resident, whose family prefers to be anonymous, (RA), out of a sample of 36 residents. This deficient practice resulted in the potentially avoidable death of RA and could	F 684		

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F 684	Continued From page 41 pose harm to other residents who have complex medical conditions. Finding includes: Record review of the "Intake Information" document retrieved from Aspen Complaints/Incidents Tracking System (ACTS) 10464. RA was admitted to the facility in August 2022 for rehabilitation, did not improve with rehabilitation, and was transferred to long term care. RA's health status significantly declined and needed to be emergently transferred to the emergency room (ER) on 12/06/22. RA was admitted to an acute care provider with a diagnosis of pneumonia (an infection in the lungs) and passed away two days later. Record review of RA's electronic health record (EHR). Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 09/05/22 revealed that RA was admitted to the facility on 08/31/22 from a hospital. RA had the following medical diagnoses: irregular heart rate, heart failure (a weakened heart that cannot supply the body with enough oxygen), an active cancer (multiple myeloma) of a type of white blood cells (WBCs) that produce antibodies to help the body fight off infections, an anemia (low blood cell count) where the bone marrow cannot produce new WBCs, red blood cells (RBCs, provides oxygen to all cells in the body), and platelets (helps to clot and stop bleeding). RA received chemotherapy and transfusions while hospitalized. Read the discharge summary from the hospital filed on 08/31/22 at 08:44 AM. R378's physician agreed to hold RA's chemotherapy regimen while RA received short-term rehabilitation (STR) at the long term care facility.	F 684		

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F 684	Continued From page 42 Record review of progress notes revealed a "Incident Note" documented on 10/14/22 at 02:39 PM by a nurse that described a fall that RA sustained. RA was found on the floor by a nurse's aide with the wheelchair located close to his head. RA stated that he fell out of his wheelchair because he fell asleep from feeling tired after receiving physical therapy. A "General" note documented by a nurse on 10/17/22 at 02:59 PM stated that RA required a blood transfusion on 10/17/22 and was transferred to an acute care provide to receive the blood transfusion. "Nutrition/Dietary Note" documented on 10/19/22 at 01:44 PM by the Registered Dietitian (RD) revealed that RA progressively lost weight. On 09/21/22, RA weighed 144 pounds and on 10/17/22, RA weighed approximately 126 pounds. "Health Status Note" documented on 10/30/22 at 01:31 PM by a nurse, stated that while RA sat up in a wheelchair visiting with his family, RA complained to his family that he did not feel well and was assessed by the nurse to be pale and complained of dizziness (symptoms of low blood pressure). A "General" note documented on 10/31/22 at 03:31 PM stated that RA had blood pressure (BP) changes while changing his position. RA's BP while lying down was 132/86 mmHg (milimeters of mercury) (normal BP is 120/80 mmHg) and sitting BP was 76/49 mmHg (normal is 120/80 mmHg). RA's medical doctor (MD)1 was notified but no directive was given. "Nutrition/Dietary Note" documented on 11/21/22 by the RD revealed that RA weighed 122 pounds on 11/05/22. "Nutrition/Dietary Note" documented by the RD on 12/05/22 at 11:30 AM stated that RA refused to eat and had continued nausea with vomiting despite the use of an antiemetic (medication used to treat nausea and vomiting).	F 684		

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F 684	Continued From page 43 There was no documentation by a nurse between the dates of 11/29/22 through 12/05/22 leading up to the following situation. Read "SBAR [situation, background, action, and response]" progress note documented on 12/06/22 at 11:45 AM. It stated that RA was to be transferred to the hospital for RA's complaints of weakness and needed further evaluation and treatment of low blood pressure. Record review of the physician's progress notes. On 10/14/22, MD1 documented that RA had a fall and that his fluid status was stable. On 10/18/22, MD1 documented again that RA's fluid status was stable, in addition to "Monitor weights. Anemia [low blood count] monitor Plan of care." On 11/01/22, MD1 documented that RA was doing well with a stable fluid status, " ... Monitor weights. Hypertension [high blood pressure]. Blood pressure levels have been within normal limits ..." MD1 documented on 11/22/22 and 11/30/22, " ... Continue present therapy to maintain current health status ..." On 08/10/23 at 10:39 AM, conducted a phone interview with MD1. MD1 stated that RA's diagnosis of multiple myeloma had associated conditions of low blood count, malnutrition, and a compromised immune system that could render RA susceptible to infections. Laboratory blood counts should be done frequently. Intravenous fluid (IVF) would have been given if RA's blood pressure was below 80, but was cautious to do so because of RA's diagnosis of heart failure. On 08/10/23 at 11:31 AM, interviewed Unit Manager (UM)1 in her office. UM1 stated that if a resident had low blood pressure, laboratory and medication checks should be done, in addition to	F 684		

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F 684	Continued From page 44 conferring with the physician. A resident's problem with malnutrition and/or low blood pressure would be assessed for the possible cause as the resident could have an infection. A problem with orthostatic hypotension would require the interventions of checking blood pressures in different positions (lying, sitting, and standing), to closely monitor the resident if he/she is sitting up, and other safety measures. The resident's care plan should be revised for any new problem identified as it drives the care and treatment the resident should receive. Record review of RA's care plan with last care plan review date of 09/28/22. There was no personalized problem with associated care interventions identified for RA's active cancer (multiple myeloma) that wasn't currently treated with RA's chemotherapy regimen and associated conditions of anemia, malnutrition, and high potential for infection. There was no problem for RA's orthostatic hypotension identified, in addition to the needed interventions for personalized treatment and care. RA's problem of ongoing malnutrition was not addressed and therefore, there were no personalized care interventions to treat this condition.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		

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F 690	Continued From page 45 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to provide appropriate services to prevent urinary tract infection for one out of four residents (Resident (R) 43) sampled. This deficient practice exposes the resident to possible infection causing contaminants and has the potential to affect all residents with urinary catheters. Findings Include:	F 690		

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F 690	Continued From page 46 On 08/07/23 at 09:58 AM, during initial observations, R43 was lying supine in bed with head elevated watching television. Observed R43 had a urinary catheter draining light yellow urine into a covered drainage bag that was on the floor. After initial observation of all 47 residents in the unit was completed, noted the drainage bag was still on the floor at the following times: 11:12 AM, 11:44 AM, 12:29 AM, 01:33 PM and 2:42 PM. On 08/08/23 at 08:20 AM, observed urinary catheter drainage bag was on the floor. Record review revealed that a urine analysis (urine test to check for infections) was done on 08/08/23. Further review revealed that R43 already had a urinary tract infection in June 2023. On 08/09/23 at 12:58 PM, concurrent interview and record review conducted with Unit Manager (UM) 1 at the nurses' station. Asked UM1 what was the reason for the urine analysis done on 08/08/23 for R43. UM1 responded they wanted to see if R43 still had an infection since he has not had any symptoms for a while. Asked UM1 if R43 has had urinary tract infections in the past, she responded that R43 also had an infection in February 2023. Asked UM1 if the drainage bag was supposed to be off the floor, she responded, "Yes, to prevent infections." Shared with UM1 multiple observations of R43's urinary catheter drainage bag being on the floor the past 2 days. UM1 said she will educate the staff and monitor. Review of facility policy, "Catheter Care, Urinary" with a revision date of September 2014 stated, " ... Infection Control. . . b. Be sure the catheter tubing and bag are kept off the floor. . ."	F 690		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills	F 693		

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F 693	Continued From page 47 CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the appropriate treatment and services to assess an identified complication, and prevent further potential complications related to enteral tube-feedings (TF) for 1 of 3 residents sampled (Resident (R)84). As a result of this deficient practice, the facility placed the resident at risk for continued avoidable complications. This deficient practice has the potential to affect all residents at the facility receiving enteral feedings. Findings include:	F 693		

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F 693	Continued From page 48 Resident (R)84 is a 32-year-old male admitted to the facility on 12/11/18 for long-term care. R84's active diagnoses include but are not limited to a personal history of traumatic brain injury, chronic respiratory failure, and functional quadriplegia (a form of paralysis that affects all four limbs, plus the torso). R84 does not speak and is incapable of voluntary movement of his limbs or head, and is dependent on enteral tube-feedings (TF) for all nutrition. In addition, R84 does not reliably/consistently respond to verbal stimuli, so cannot be assessed for cognitive status. On 08/08/23 at 02:11 PM, observed certified nurse aide (CNA)6 and CNA8 changing R84's adult disposable brief. R84's brief and under-pad visibly saturated with large areas of beige-colored liquid. The appearance and smell of the liquid was consistent with enteral feeding formula. Observation confirmed by the 2 CNAs present. Asked if the licensed nurse had been notified. CNA6 responded that they would let her know. On 08/08/23 at 02:30 PM, an interview and concurrent observations were done with licensed practical nurse (LPN)1 both outside R84's room and at his bedside. LPN1 stated that the CNAs had just informed her of the TF formula on R84's brief and under-pad, and was just about to go in to check for residual (the volume of fluid remaining in the stomach). LPN1 reported that the last TF had been connected at 12:00 PM, and the next feeding was due at 04:00 PM. LPN1 stated her intention to check for residual, and if there was only a small amount, she would give another feeding and "endorse" it to the next shift so that they could adjust future feedings accordingly. When asked, LPN1 stated she	F 693		

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F 693	Continued From page 49 could not remember if she was the one who disconnected R84's 12:00 PM feeding and flushed his gastric tube with water as per the physician order. Followed LPN1 into R84's room where she found less than 10 milliliters (mLs) of residual. LPN1 did not perform any assessment or investigation as to how or why the previous TF ended up on the resident. As LPN1 prepared to reconnect and start another TF, asked her if this was something she wanted to inform the physician about. LPN1 was unsure why the physician would want to know. With Surveyor prompting, LPN1 agreed that she would inform the physician and let him decide if/how to adjust the TF orders. On 08/08/23 at 02:43 PM, an interview was done with Unit Manager (UM)3 in her office. UM3 confirmed that she would have expected LPN1 to know to inform the physician without prompting, and to troubleshoot possible leakage from the gastric tube. UM3 stated one of the first things LPN1 should have done was visualize the gastric tube insertion site and dressing to check for leakage. On 08/08/23 at 02:52 PM, LPN1 informed UM3 that she had notified the physician and received an order to give a one-time replacement feeding. Surveyor followed LPN1 back into R84's room. Observed LPN1 as she instilled air into the gastric tube, auscultated with her stethoscope for bowel sounds, checked residual, then flushed the gastric tube with water and reconnected the TF via a pump. At no time did LPN1 check the gastric tube insertion site or dressing for leakage, as they remained under R84's gown and not visible as she worked then prepared to leave the room.	F 693		

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F 693	Continued From page 50 A review of R84's TF Care Plan revealed the following: "Monitor/document/report [to the physician] PRN [as needed] any s/sx [signs or symptoms] of: ... Tube dislodged, Infection at tube site, Self-extubation, Tube dysfunction or malfunction ..." A review of the facility policy and procedure on Enteral Tube Feeding, last revised November 2018, revealed the following under Reporting: "1. Report complications promptly to the supervisor and the Attending Physician."	F 693		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		

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F 726	Continued From page 51 §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review (RR), the facility failed to ensure nurse competency in medication administration as evidenced by an extended release tablet being crushed and administered to a resident. This deficient practice places the residents at risk for avoidable declines in health status and decreased quality of care and has the potential to affect all the residents at the facility receiving crushed medications. Findings include: On 08/09/23 at 07:51 AM, medication pass observations were done with licensed practical nurse (LPN)1 as she prepared and administered medications for Resident (R)25. Observed LPN1 remove a potassium chloride ER (extended release) 10mEq (milliequivalent) tablet from the blister pack and place it into a medication cup. The blister pack had a bold pharmacy label prominently placed that read "Do not crush ..." A minute later, after LPN1 had prepared the other 6 medications for R25, LPN1 proceeded to crush the potassium chloride ER tablet.	F 726		

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F 726	Continued From page 52 At 08:01 AM, the crushed potassium chloride was administered via a gastric tube to R25. At 08:18 AM, an interview was done with LPN1 outside R25's room. When asked, LPN1 reported she was "not sure" if the pharmacy is OK with the potassium chloride ER being crushed for administration. At 09:44 AM, an interview was done with Unit Manager (UM)3 in her office. UM3 confirmed that extended release tablets should not be crushed, and stated that LPN1 should know that. A review of R25's physician orders revealed no orders to crush the potassium chloride ER. A review of the facility policy Crushing Medications, last revised April 2018, revealed the following: "Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders."	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		

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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 interviews and record review, the facility failed to ensure that records for controlled medications are in order and that an accurate account is maintained and reconciled. The staff did not document the actual amount of medication in the container and signed off on medications not yet administered. As a result of this deficiency, there is a potential for the diversion of controlled medications.

Findings include:

1) On 08/09/23 at 08:20 AM, conducted an inspection of a medication cart with Nursing Staff (NS)34. Review of the Controlled Medication Sign-Off sheet documented NS34 had pre-signed the sheet of the count that is to be preformed with

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the on-coming evening shift nurse later in the day. NS34 confirmed the sheet controlled medications sheet was pre-signed and should not have been, it should have been signed in the presence of and witnessed by the on-coming shift immediately after the count was verified as accurate. The purpose of the on-coming and off-going nurses conducting and verifying the controlled medication count serves as part of the facility's system to account for all controlled medication, reduce the potential for diversion, and to more readily identify/recognize an attempt to diverge controlled medications.

At 08:25 AM, conducted an interview with the Unit Manager (UM)3 regarding NS34 pre-signing the controlled medication audit list. Informed UM3 of the observation and UM3 confirmed the controlled medication audit sheet should not be pre-signed and should be signed in the presence of the on-coming licensed staff, immediately after verifying the controlled medication count together.

Review of the facility policy "Medication Administration Controlled Substances" (2007 PharMerica Corp, Nursing Care Center Pharmacy Policy & Procedure Manual), "7. At each shift change, a physical inventory of controlled medications, as defined by state regulation, is conducted by two licensed clinicians and is documented on an audit record."

2) On 08/09/23 at 10:22 AM, observation of medication cart in Unit 2 was done with Registered Nurse (RN) 18. Review of the "Controlled Drug Record" revealed that the remaining amount in a bottle of liquid medication (Phenobarbital) was documented as 200 milliliters (ml) with amount received at 320 ml. Actual

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amount of medication in the bottle was observed at 245 ml. RN18 confirmed the actual amount in the bottle was 245 ml. RN18 said the staff sign off on the amount noted in the log but verbally endorse what the actual amount is in the bottle. RN18 added that when the log is at zero, two nurses would note the amount left over in the bottle on the back of the "Controlled Drug Record" and it will be discarded. Asked RN18 if they document the amount of overage anywhere, he said, "We don't, we just endorse." Requested a copy of the log from RN18.

On 08/10/23 at 08:53 AM, an interview was conducted with the Director of Nursing (DON). Shared observed discrepancy with the medication log and amount in the container for the controlled medication. DON said, "I will look into it." When asked if the pharmacy overfills liquid medications, she confirmed that they do not overfill the containers. DON said the pharmacy delivers the actual amount noted on the log that comes with the medication. DON shown a copy of the log where the remaining amount was documented as 200 ml and the actual amount observed was 245 ml. Amount received was also noted as 320 ml and that there were 16 doses of 20 ml. On the row after the first dose was administered, the amount documented was 280 ml. Asked DON if 280 ml is correct, she said, "It should be 300 ml." DON then said she will talk to the nurse and correct it.

On 08/10/23 at 10:00 AM, interview with RN18 conducted. RN18 stated, "I may have mistaken the two for a zero on the amount received." RN18 also confirmed that the nurses, "write down what the amount should be in the log and verbally endorse what the actual amount is." RN18 also

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F 755	Continued From page 56 confirmed that the information is not documented anywhere. Review of the facility policy "Medication Administration Controlled Substances" stated, ". . . 9. Any discrepancy in a controlled substance medication count is reported to the director of nursing immediately. . . The DON investigates the discrepancy and researches all the records related to administration and the supply of the medication, including medication reconciliation. . ."	F 755		
F 756 SS=D	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	F 756		

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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.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that medication regimen irregularities were identified, reported, and addressed for 1 of 5 residents sampled (Resident (R)74). As a result of this deficient practice, the resident was placed at risk of avoidable complications related to his documented medication allergies. This deficient practice has the potential to affect all residents at the facility receiving medications.

Findings include:

Resident (R)74 is a 69-year-old male admitted to the facility on 09/07/21 for long-term care. R74's active diagnoses include but are not limited to chronic respiratory failure, and dependence on a respirator (ventilator) for breathing.

On 08/09/23 at 10:33 AM, during a record review of his electronic health record (EHR), the following orders were noted:

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F 756	Continued From page 58 05/11/23 "Trazodone HCl [hydrochloride] Oral Tablet 50 MG [milligrams] (Trazodone HCl) Give 0.5 tablet by mouth as needed for Sleep. For 6 months at bedtime. Hold for sedation." 06/23/23 "AVOID trazodone and psyllium per Dr ...." Also noted at this time was that R74's listed allergies were trazodone and psyllium, and had been recorded upon his admission. Further review of the EHR noted that the trazodone was originally ordered in April 2023. Review of the Medication Administration Records (MARs) from April through August revealed that the facility had administered trazodone to R74 three times in July 2023. On 08/10/23 at 02:33 PM, an interview was done with Unit Manager (UM)3 at the Ventilator Care Unit (VCU) nurses' station. UM3 confirmed that R74 had a documented allergy to Trazodone, yet had a current order for the medication. UM3 could not explain why the order was still active despite the listed allergy and the 06/23/23 order by the physician to avoid the medication. UM3 questioned why the pharmacy did not catch the allergy and why they sent the medication to the facility, and agreed that the discrepancy should have been noticed by someone. UM3 could not explain why the medication had been given three times in July as nurses are trained to check allergies prior to giving any medication.	F 756		
F 761 SS=E	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	F 761		

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F 761	Continued From page 59 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all medications used in the facility were labeled in accordance with professional standards. Proper labeling of medications is necessary to promote safe administration practices and decrease the risk for medication errors. This deficient practice has the potential to affect all residents in the facility who take medications. Findings include: On 08/09/23 at 08:49 AM, an inspection of the Ventilator Care Unit (VCU) medication cart #3	F 761		

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was done with licensed practical nurse (LPN)1. Observed in the 3rd drawer of the cart were the following unlabeled bottles of over-the-counter (OTC) vitamins/supplements:

1 open bottle of Tangy Tangerine Tablets 2.0
1 open bottle Z-Stack vitamin
1 closed bottle Z-Stack vitamin

Interview done with LPN1 revealed the unlabeled bottles were medications (with accompanying physician orders) for Resident (R)9. LPN1 stated that R9's family brings the medications in from the outside, and that the facility holds and administers them from the medication cart. LPN1 confirmed that the bottles should be labeled with the resident's name at a minimum.

At 09:02 AM, an emergency kit (E-Kit) insulin pen was found in the medication cart for R10, who had been transferred to an acute care facility 3 days ago. The insulin pen had E-Kit pharmacy labels with only R10's last name written in ball point pen on one of the labels.

LPN1 confirmed that E-Kit insulin pens should be labeled with the first and last name of the resident, as residents can often have the same or similar last names.

On 08/09/23 at 09:22 AM, an interview was done with Unit Manager (UM)3 at the VCU nurses' station. UM3 confirmed that all bottles in the medication cart, especially those brought in by family, should be labeled with the first and last name of the resident and their room number prior to being placed in the medication cart. UM3 also verified that insulin pens used from the E-Kit should be labeled with first and last name of the

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F 761	Continued From page 61 resident as well. Review of the facility policy and procedure Medications Brought To Nursing Care Center By Resident Or Responsible Party, last revised 12/12, revealed the following: "1. Use of medications brought to the nursing care center ... is allowed only when ... b. The medication container is clearly labeled and packaged in accordance with pharmacy procedures for medication labeling and packaging ..."	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, 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:	F 812		

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F 812	Continued From page 62 Based on observations and interviews, the facility failed to ensure food was stored and prepared in accordance with standards for food safety. As a result of this deficient practice, all resident have the potential to be affected and experience harm. Findings include: 1) On 08/07/23 at 08:44 AM, during the initial brief tour of the kitchen, observed an open box of Holten Beef Patty and an open bag of diced potatoes (in an unlabeled box) in the freezer. The beef patties and diced potatoes were both open to the freezer air and appeared to have freezer burn. The Dietary Director (DD)1 was present and confirmed the open bags of beef patties and diced potatoes should have been sealed properly, but was not, and both items were freezer burnt. DD1 removed the beef patties and diced potatoes from the freezer. 2) On 08/09/23 at 11:37 AM, during a follow-up visit to the kitchen, observed staff plating resident's lunches. Observed a pot on the stove that contained cooked chicken (alternative/special request) which was served to at least one resident. Although the pot was on the stove, there was no heat source and to keep the chicken at 135 degrees Fahrenheit throughout the plating process. At 12:15 PM, after the last cart was completed, requested for Kitchen Staff (KS)2 to take the temperature of the chicken and the internal temperature of the chicken was 104 degrees Fahrenheit. KS2 confirmed the cooked chicken was not held at 135 degrees Fahrenheit or higher while plating and should have been.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842	Continued From page 63 §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		

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F 842	Continued From page 64 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to maintain medical records on 1 of 36 residents sampled (Resident (R)25) that were complete and accurately documented. As a result of this deficient practice, the medication administration record (MAR) for R25 was incorrect until the state agency (SA) pointed out the discrepancy. Timely and accurate medical record documentation, especially of medications administered, is essential for the care of any resident. This deficient practice has the potential to affect all the	F 842		

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	125019	A. BUILDING _____ B. WING _____	08/10/2023

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F 842	Continued From page 65 residents at the facility. Findings include: On 08/09/23 at 07:51 AM, medication pass observations were done with licensed practical nurse (LPN)1 as she prepared and administered medications for Resident (R)25. Observed LPN1 administer and/or attempt to administer 7 medications to R25. 6 medications were given via her gastric tube. The seventh medication was a mouth rinse that LPN1 tried to administer, however R25 did not tolerate even the small amount attempted via a disposable oral swab, so LPN1 wasted most of it. At 09:30 AM, while attempting to verify if LPN1 had correctly documented the wasted medication on the MAR, SA noted that none of the medications given to R25 had been signed off yet. At 09:44 AM, an interview was done with Unit Manager (UM)3 in her office. After verifying that the medications were not signed off yet in the EHR, UM3 stated that the expectation is that medications are documented as administered as soon as they are given. UM3 continued that licensed nurses should not be waiting until the end of the shift to document medications as given. UM3 stated she would address it with LPN1. On 08/09/23 at 02:57 PM, a review of R25's MAR revealed that 6 of the 7 medications administered to R25 that morning were documented as given by Registered Nurse (RN)25, and not LPN1. In addition, the 1 medication documented as given by LPN1, the mouth rinse, was documented as if	F 842		

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F 842	Continued From page 66 the entire dose was given. At 03:04 PM (the end of the shift), another interview was done with UM3 in her office. UM3 confirmed that the documentation for the mouth rinse was inaccurate and should reflect that part of it was wasted. UM3 called LPN1 into the office to provide guidance on how to document it accurately. After the discussion was over, SA asked about the other 6 medications being documented as given by a different nurse. LPN1 stated she meant to correct that at the end of the shift. UM3 stated she would have expected to be notified of a mistake like that as soon as the mistake was found because "IT [Information Technology Department] needs to be involved and they are located in California." As a result of waiting until the end of the shift, UM3 stated that the issue needed to be "escalated" to the Director of Nursing (DON) because since IT was already closed for the day, it could not be addressed until the next day. A review of R25's MAR done directly prior to survey exit on 08/10/23 revealed that 1 of the 7 medications administered the day before still showed as administered by the wrong licensed nurse.	F 842		
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.	F 880		

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F 880	Continued From page 67 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(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	F 880		

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F 880	Continued From page 68 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to perform proper hand hygiene and follow infection control processes. This deficient practice places the residents and visitors at risk for the development and transmission of communicable disease and infections. Based on observation, interview, and record review, the facility failed to ensure appropriate protective and preventive measures for communicable diseases and infections. This is evidenced by the facility failing to ensure staff followed transmission-based precautions (TBP) by wearing the proper personal protective equipment (PPE), as well as follow standard precautions by performing hand hygiene in between glove changes. These deficient practices have the potential to affect all residents	F 880		

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F 880	Continued From page 69 in the facility, as well as all healthcare personnel, and visitors at the facility. Findings include: 1) Observation was conducted on 08/07/23 at 08:14 AM near the front entrance on the first floor. Infection Preventionist (IP) was performing rapid Covid testing to facility visitors. IP swabbed the first surveyor and removed his gloves. IP was observed donning new gloves without sanitizing his hands first. IP then assisted five other surveyors with self-swabbing without changing out his gloves. Interview was conducted on 08/09/23 at 09:17 AM on the first floor. IP was asked when should staff perform hand hygiene. IP answered that hand hygiene should be performed every time patient care is performed and in between gloves. IP agreed that he should have hand sanitized in between glove use while performing Covid testing. He also added that it would have been a good idea to change out his gloves while assisting the five surveyors with self-swabbing, since each specimen was from a different person. A review of the facility's document titled, "Handwashing/Hand Hygiene," dated August 2019 was conducted. The document indicated, "Perform hand hygiene before applying non-sterile gloves ...use an alcohol-based hand rub containing at least 62% alcohol or soap and water for the following situations ...after removing gloves." 2) On 08/07/23 at 12:07 PM, observed certified nurse aide (CNA)7 repositioning Resident (R)48 to prepare him for lunch. R48 is a	F 880		

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F 880	Continued From page 70 ventilator-dependent resident who is on enhanced-barrier precautions, meaning staff who are providing direct care should be wearing an N-95 respirator, a gown, and gloves. CNA7 was observed touching his bedding, gown, and underpad without wearing a gown or gloves. At 12:12 PM, an interview was done with CNA7 outside R48's room. CNA7 acknowledged that she should have gowned and gloved to reposition him. CNA7 stated she thought she was just "dropping his tray" but when he asked to be repositioned, she should have exited the room to gown and glove up.) On 08/08/23 at 02:11 PM, observed CNA6 and CNA8 changing R84's adult disposable brief. R84 is a ventilator-dependent resident who is on enhanced-barrier precautions, meaning staff who are providing direct care should be wearing an N-95 respirator, a gown, and gloves. CNA6 was observed not wearing a gown as she and CNA8 repositioned R84 to change his brief. When asked about it, CNA6 stated she had been wearing one when changing the resident in bed 3, but when she came over to bed 1, she forgot to don (put on) a new one. As she and CNA8 changed R84's disposable brief, observed CNA6 change her gloves multiple times with no hand hygiene in between.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	F 921		

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F 921	Continued From page 71 by: Based on observations and staff interview, the facility failed to secure an electrical panel on Nursing Unit 4. As a result of this deficient practice, the facility put the safety and well-being of the residents as well as the public at risk for accident hazards. Findings include: During an observation of Nursing Unit 4 on 10/07/23 at 10:00 AM, the electrical panel was not secured. The panel contained electrical circuit switches numbered one to thirty five. No staff members were in the immediate vicinity to prevent any residents and/or visitors from accessing the electrical panel. Second observation of Nursing Unit 4 on 10/08/23 at 11:00 AM showed the same electrical panel was not secured. Again, no staff members were in the immediate vicinity to prevent any residents and/or visitors from accessing the electrical panel. During staff inquiry on 10/09/23 at 08:30 AM, the Administrator acknowledged that the electrical panel should have been secured. Administrator stated that they would immediately have the electrical panel secured/locked.	F 921		