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| E 000 | Initial Comments<br><br>An unannounced Emergency Prepardness survey was conducted 06/22/2021 through 06/24/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 06/22/2021 through 06/24/2021. One complaint was investigated. VA00052193 was substantiated with related deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 143 certified bed facility was 124 at the time of the survey. The survey sample consisted of twenty-five (25) current resident reviews, and two (2) closed record reviews. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>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.<br><br>§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. | F 550 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/15/2021

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| F 550 | Continued From page 1<br><br>§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.<br><br>§483.10(b) Exercise of Rights.<br>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.<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to promote dignity and respect for one of 27 residents in the survey sample, Resident #43. Facility staff provided incontinence care and a bed linen change while the resident was verbally refusing the care.<br><br>The findings include:<br><br>Resident #43 was admitted to the facility on | F 550 | | |

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6/6/20 with diagnoses that included chronic kidney disease, atherosclerotic heart disease, heart failure, diabetes, cellulitis, anemia, peripheral vascular disease, major depressive disorder, left eye blindness and peripheral neuropathy. The minimum data set (MDS) dated 3/5/21 assessed Resident #43 with moderately impaired cognitive skills, as frequently incontinent of bladder, with little interests in doing things and having feelings of being down, depressed and/or hopeless. The MDS dated 4/14/21 documented the resident required the extensive assistance of two people for bed mobility and the extensive assistance of one person for toileting/hygiene.

On 6/22/21 at 3:00 p.m., Resident #43's door was closed. Resident #43 was heard from the hall outside his room shouting loudly that he did not want to be changed. The resident cursed multiple times stating he did not want to be changed and shouted, "Leave me alone." Resident #43 loudly shouted that if they did not leave him alone he would "piss all over everything." The resident continued to curse and verbally stated he did not want to be changed. On 6/22/21 at 3:08 p.m., two staff members exited the resident's room. Resident #43 was observed sitting on the bedside at this time and was interviewed about what just occured and why he was upset/shouting. Resident #43 was shaking his head and stated he was upset because, "They made me change my clothes...made me change my whole bed." Resident #43 stated he was resting, not bothering anyone and staff just came in and said he had to be changed. Resident #43 stated, "They were giving me hell...said I was wet and I wasn't wet." Resident #43 stated, "I was sleeping, feeling good and they come in and changed everything."

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Resident #43 stated again, "They put me through hell...I did not want to go through that. I was fine."

On 6/22/21 at 3:21 p.m., licensed practical nurse (LPN #4) that was with Resident #43 during the incontinence care/bed change was interviewed. LPN #4 stated she noted the resident's left foot was hanging off the bed and she attempted to reposition it. LPN #4 stated the resident "was not ready earlier" for a brief or bed change and the aide had been in several times but the resident refused. LPN #4 stated she and certified nurses' aide (CNA) #2 attempted to pull the resident up in bed and saw the sheets were wet. LPN #4 stated the resident denied he was wet, accused them of pouring water in the bed, cursed loudly and called them names repeatedly. LPN #4 stated they were able to complete the brief/linen change because the resident was turning as he was cursing. LPN #4 stated Resident #43 attempted to hit at CNA #2 when she tried to assist him. LPN #4 stated she and CNA #2 completed the brief/linen change despite the resident cursing. LPN #4 stated the resident was turning in bed "in the midst of cursing." When asked about the protocol for providing care for residents refusing or being combative, LPN #4 stated usually they would leave them and attempt care at a different time. LPN #4 stated they had attempted care with Resident #43 earlier in the shift but the resident refused.

On 6/23/21 at 10:30 a.m., CNA #2 that was with Resident #43 during the brief/linen change on 6/22/21 was interviewed. CNA #2 stated Resident #43 wet the bed "all the time." CNA #2 stated, "You can't go home and leave a patient wet in bed." CNA #2 stated it was the end of her shift yesterday (6/22/21) and she was not going to

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leave Resident #43 and his bed wet for the next shift. CNA #2 stated Resident #43 did not want to be changed. CNA #2 stated, "I had to do it [change resident] or they will write me up." CNA #2 stated she and LPN #4 changed the resident's t-shirt, brief and sheets. CNA #2 stated the resident followed instructions to turn from side to side so they could change him but the resident was cursing and shouting the entire time. CNA #2 stated the resident did not want his brief or bed changed and again stated she had to change the resident because it was the end of her shift. CNA #2 stated Resident #43 at times would say he was dry when he was actually wet and the resident "gets angry" at times when care was attempted. When asked why they proceeded with the brief/linen change when the resident was shouting and refusing, CNA #2 stated she was not going to leave him wet for the next shift. When asked what she does when residents refuse care, CNA #2 stated she was supposed to report the refusal to the nurse. CNA #2 stated the nurses usually told her to wait and attempt care later. CNA #2 stated yesterday (6/22/21) she had tried earlier in the shift to change Resident #43 but he refused. CNA #2 stated again she proceeded with the change against the resident's refusal because she was not leaving him and the bed wet for the next shift.

On 6/23/21 at 5:30 p.m., the director of nursing (DON) was interviewed about Resident #43's care provided while the resident was verbally refusing. The DON stated if the resident was exhibiting behaviors, the CNA should go get the nurse and attempt care later or with different staff members.

Resident #43's plan of care (revised 6/7/21)

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documented the resident had behaviors that included feelings of wanting to die, not wanting to live, cursing at staff, refusing care/assistance including incontinence care, calling staff names and throwing items. The plan of care documented the resident required assistance with activities of daily living (ADL's) due to right above knee amputation and deteriorated physical condition. Interventions for behaviors and providing ADL care included, "...Honor [Resident #43's] choices and preferences whenever possible...coordinate [Resident #43's] preferred dressing/grooming routine...Allow [Resident #43] to make decisions about treatment regime, to provide sense of control...If possible, negotiate a time for ADLs so that the resident participates in the decision making process. Return at the agreed upon time...If resident resists with ADLs, reassure resident, leave and return 5 - 10 minutes later and try again...Caregivers to provide opportunity for positive interaction, attention...give resident 1:1 time to express feeling/concerns..."

The facility's policy titled Refusal of Care and Treatment (effective 2/18/19) documented, "...It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...The facility honors the cognitively intact residents right to refuse care and treatments...The facility will make consideration for residents to the extent possible who are cognitively impaired and attempt to determine the reason for the refusal and provide potential solutions..."

This finding was reviewed with the administrator and director of nursing (DON) during a meeting on 6/23/21 at 5:10 p.m.

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| F 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) | F 558 | | |

§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, resident interview, staff interview and clinical record review, the facility staff failed to provide an accessible light switch for one of 27 residents in the survey sample, Resident #21. Resident #21's over-bed light was not equipped with a cord so the resident could turn the light on/off as desired.

The findings include:

Resident #21 was admitted to the facility on 2/26/16 with a re-admission on 10/3/19. Diagnoses for Resident #21 included right shoulder/hand contracture, spinal stenosis, dysphagia, hypertension, dementia with behaviors, congestive heart failure, lymphedema, seizures, osteoarthritis, cerebral infarction and neuropathy. The minimum data set (MDS) dated 4/1/21 assessed Resident #21 with moderately impaired cognitive skills and adequate vision (sees fine details).

On 6/22/21 at 12:45 p.m., Resident #21 was observed in his room and was interviewed at this time about quality of care and life in the facility. The resident stated he was not able to turn his over-bed light on/off because he had no string/cord attached. Resident #21 stated he used the outlet on the over-bed light fixture for

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| F 558 | Continued From page 7<br>charging his cell phone and he was not able to reach the short chain on the light. The over-bed light was inspected at this time. The chain attached to the on/off switch was approximately 3 inches in length and not accessible from the bed or the resident's wheelchair. There was a cell phone charger plugged into the outlet on the over-bed light fixture.<br><br>On 6/23/21 at 3:46 p.m., accompanied by the licensed practical nurse unit manager (LPN #3), Resident #21's over-bed light was observed. LPN #3 was interviewed at this time about the short chain and lack of accessibility for the resident. LPN #3 stated he was not aware of the short chain. LPN #3 stated the resident was able to turn the light on/off and there should be a cord attached.<br><br>Resident #21's plan of care (revised 2/18/21) documented the resident had degenerative joint disease, contractures, was at risk of falls due to balance problems, poor safety awareness and cognitive impairment. Interventions to minimize pain and promote safe environment included, "Anticipate and meet resident's needs...Provide safe environment...adequate, glare-free light...personal items within reach..."<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/23/21 at 5:15 p.m. | F 558 | | |
| F 584 SS=E | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including | F 584 | | |

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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 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 resident interview, staff interview,

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facility document review and during the course of a complaint investigation, the facility staff failed to ensure reasonable care and protection of resident property from loss and/or theft for one of 27 residents (Resident #10) regarding an iPad and a framed painting; and failed to ensure a safe homelike environment for one of 27 residents (Resident #21) regarding the resident's room, room equipment and room furnishings.

Findings include:

1. Resident #10 was admitted to the facility originally on 12/13/19, with the most current readmission on 06/22/21. Diagnoses for Resident #10 included, but were not limited to: repeated falls, conversion disorder with seizures, narcolepsy, history of a stroke with left side paralysis, major depressive disorder, cognitive communication deficit, and dementia without behaviors.

The most current MDS (minimum data set) was a quarterly assessment dated 06/03/21, which assessed the resident with a cognitive score of 15, indicating the resident was intact for daily decision making skills. The resident required extensive assistance from at least one staff person for most ADL's (activities of daily living).

On 06/23/21 at 11:36 AM, Resident #10 was interviewed in her room. Resident #10 stated that she had a framed painting of the Canadian mountains taken out of her room and that she was told it was now in the maintenance director's office and his name was [OS (other staff #8]. The resident stated that staff had told her that the glass was cracked and that is why it was removed from the resident's room to that office

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and that it was supposed to be repaired and brought back to her room. Resident #10 could not say exactly when that occurred, but stated it had been a long while. Resident #10 also stated that she had a brand new iPad that was lost or stolen. The resident couldn't recall the exact time that happened, but stated probably 6 months or longer. Resident #10 stated that since the iPad was taken, a friend of the resident had purchased her another iPad and stated that the other one has never been found or recovered. Resident #10 could not remember specific dates as to when the items were lost or stolen, but stated that she had reported this to the SW [social worker] and also stated that she thought she had reported it to the UM [unit manager, also known as LPN (licensed practical nurse) #8].

The resident's clinical records were reviewed. Three personal effects inventory records were located in the resident's clinical record. An inventory record dated 12/14/19 documented a pair of brown pants, a wallet and a red checkbook. No other information was listed, nor any further description provided. An inventory record dated 02/22/20 documented, a computer desk, computer, keyboard, mouse and printer. No other information was listed, nor any other description provided. An inventory record dated 03/22/21 documented "no changes", nothing was listed and only had "no changes" documented.

06/23/21 2:27 PM, the SW was interviewed, regarding Resident #10's iPad and painting. The SW stated that she was aware of the items and had spoken with maintenance regarding the painting and that maintenance director said it was in the office. The SW stated that it had a crack in it. The SW was asked if she knew about the

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painting and was aware it was missing. The SW stated that she was aware of it. The SW was asked where the painting was and which office. The SW stated, "It's in the building." The SW was asked where in the building and was asked to locate the painting. The SW stated that she didn't know exactly where the painting was and wasn't sure who was responsible for repairing the painting and wasn't sure why it had not been done. The SW also stated she did not know how long the painting had been in ill repair or how long it had been in the maintenance office. The SW stated that she did recall something about an iPad, but stated that was back during COVID and stated maybe September or October [2020]. The SW stated she would have to look at her records and see what she could find and see if she had any information in her office. The SW was asked for assistance in finding the resident's personal inventory records, as the one's listed in the resident's EMR [electronic medical records] did not include the personal property in question.

On 06/24/21 at approximately 8:15 AM, the administrator, DON (director of nursing) and the UM were interviewed regarding Resident #10 and the concerns regarding the resident's painting and iPad. The UM stated as far as the iPad, that was during COVID [probably around September] and the resident was on Unit 1 [currently residing on Unit 4] and when the resident moved to unit 4 and the resident's belongings were being put away in the new room, the "iPad was gone", since then the UM stated that the resident purchased another iPad. The UM stated that she remembered Resident #10 having a new iPad [still in the box] and the resident was asking and wanting staff to help her set it up, but that the resident had a history of being "accusatory" of

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staff on different occasions regarding staff taking or moving her personal items and that staff were "afraid" to help her with it. The UM stated that Resident #10 had a room change from unit 1 to unit 4 and when the move was complete, then the iPad couldn't be found. The UM voiced that she thought she had documented about that, but wasn't sure if an investigation or anything had been done. The DON, administrator and UM were made aware that the resident stated a friend purchased another iPad after the first one was lost or stolen. The UM stated that she didn't know if an investigation was done, but would check with the SW. The UM stated as far as the painting, the UM was aware of the painting and thought it had been put up somewhere due to it being cracked.

At approximately 9:00 AM, the SW was asked again to locate the painting in the facility for observation. The SW was also asked for assistance in locating any inventory records for Resident #10 and was asked if an investigation was conducted on the lost/stolen iPad. The SW stated that she would have to look and see what she had in her office.

On 06/24/21 at 9:30 AM, the SW was asked if the painting had been found. The SW stated, "I've never seen the painting, I believe it was in the maintenance department." The SW was asked where was the painting now. The SW stated, "I don't know that I have seen it." The SW stated that she was aware of the painting and the iPad, but didn't know where they were. The SW stated, "I was told that it may have gotten moved to another area, but we have not located it and it was not on her [the resident's] inventory sheet." The SW was asked why it wasn't on her inventory

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record, as several staff were aware of these items. The SW stated, "I can't answer that." The SW was asked what was supposed to happen if a resident has personal property brought in. The SW stated it should go on the inventory list when the items were brought in. The SW was asked what was supposed to happen if resident belongings go missing. The SW stated that if a resident has a missing item, the staff write up a missing report or concern form and investigate and try to find the item. The SW was asked if this was done for Resident #10 for her iPad and her painting. The SW stated, "I can't find any documentation regarding the iPad and the same for the painting." The SW presented an inventory list for Resident #10 dated 01/08/20, which documented items of clothing, stuffed animals, throw pillows, a blanket and two hand braces, but did not document either of the the resident's iPads or the painting. This inventory sheet the SW presented came from the SW office, was hand written and did not match or include any items from the three inventory lists that were located in the resident's EMR [listed above]. The SW was asked who was OS #5. The SW stated he was the previous maintenance director and stated that they have had two since he left. The SW stated she was unsure of when he left, but it had been a while.

On 06/24/21 at 10:00 AM, the maintenance director was interviewed. The maintenance director stated that he had not seen a painting/portrait of any kind. He stated that his assistant, OS #6, told him that he had seen it and that the glass was broken and that it was stored in the control room. The maintenance director stated that OS #6 did not have any knowledge of where it was now.

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At 10:20 AM, OS #6 was interviewed. OS #6 stated that he remembered first seeing the painting "maybe April" and it was located in the electric room at that time. OS #6 stated that he last saw it about a month ago, and that it was a fairly large painting. OS #6 looked around the activity room and compared a wall hanging to the size of the resident's painting and and guessed the resident's painting to be about the size of approximately 2-3 foot wide by 1 - 1/2 to 2 foot long. OS #6 couldn't remember exactly what the painting was of, but did remember that it was cracked. OS #6 stated that he really didn't pay that much attention to it. OS #6 stated that when the phone lines were being put in, about a month or so ago that the facility had contractors in and out of the building and that they were cleaning out stuff from that room where the painting had been located. OS #6 stated that the contractors were doing work in there and cleaned a bunch of stuff out and didn't know if it had been thrown out while the construction was being completed. OS #6 stated that he hasn't seen it since and doesn't know what happened to it.

A review of the resident's nursing/progress notes documented the following:

A social services note dated, 09/09/20 at 3:58 PM documented, "...She [resident] needed reminder of where 2 pieces of some framed art were...beside her dresser...signature of SW."

A social worker note dated, 11/21/20 at 12:33 PM documented, "...She reads, works on her computer or iPad...signature of SW."

A nursing note dated 04/06/21 at 6:00 PM

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documented, "...resident is also noted frequently accusing staff of removing/taking her belongings. For example, resident has a painting that she brought from home on admission. One being a large painting that there is not enough room for in her room. This painting was with her belongings in her room but unable to hang, painting was noted with glass broken to frame and was removed and placed in storage for safety...her painting is put up for safety/safe keeping...signature of UM [LPN #8]."

The resident's current CCP (comprehensive care plan) documented, "...resident with a history of making false allegations towards staff...accuses staff of multiple things including stealing items from her room (that are found in her room untouched)...2 people to assist resident with care needs at a time...anticipate and meet resident's needs..frequent encouragement to purge items to maintain a clean and tidy living area..."

On 06/24/21 at 12:00 PM, the administrator and DON were made aware of the above concerns with Resident #10's personal belongings not being logged to ensure better inventory, and not being investigated when the resident voiced concern over the items being lost and/or stolen. The administrator and DON were made aware of the concerns regarding the resident's personal property and that according to interviews conducted and progress notes that the facility staff were aware that these personal items belonging to Resident #10 and failed to ensure proper safeguards were taken to ensure the resident's belongings were safe and secure from loss and/or theft, and as a result the items could not be located and there was no evidence of an investigation regarding the lost/stolen items.

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The DON was asked for a policy on inventory of resident's personal items and a policy or procedure on what staff were supposed to do when a resident reports items missing, stolen or damaged.

At approximately 11:00 AM, a policy documented, "...Inventory of personal effects...resident has the right to retain and use personal property including some furnishings...as space permits..unless to do so would infringe upon the rights or health and safety of other residents...labeling resident's personal property, having door on all closets, and investigating incidents of loss or damage...nursing department will complete the inventory sheet at time of admission...staff will sign and date...staff will request capacitated resident or legal representation...to sign...the social worker will mail...to responsible party...the social worker will place a copy of the inventory listing on the active record until the original is returned...Upon receipt of an oral, written or anonymous grievance submitted by a resident...will take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated...misappropriation of property...will immediately notify the administrator and the allegation will reported and investigated...."

The DON and administrator stated that they could not locate any previous documentation and/or investigations regarding Resident #10's personal property, but stated that an investigation should have been completed and that personal items are supposed to be logged on the resident's personal property inventory record.

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No further information and/or documentation was presented prior to the exit conference on 06/24/21 at 12:30 PM.

This is a complaint deficiency.
2. Resident #21 was admitted to the facility on 2/26/16 with a re-admission on 10/3/19. Diagnoses for Resident #21 included right shoulder/hand contracture, spinal stenosis, dysphagia, hypertension, dementia with behaviors, congestive heart failure, lymphedema, seizures, osteoarthritis, cerebral infarction and neuropathy. The minimum data set (MDS) dated 4/1/21 assessed Resident #21 with moderately impaired cognitive skills.

On 6/22/21 at 11:45 a.m. Resident #21's room/furnishings were inspected. The doorknob to the restroom was dented and partially detached from the door. The bathroom door was difficult to open and/or close with use of the loose knob. The door to Resident #21's wardrobe was detached from the hinges and positioned in the floor beside the wardrobe leaning against the wall. The edges to the top of the resident's dresser were deteriorated with particleboard visible. Veneer was stripped and hanging on the bottom left frame of the dresser. The wall above the air conditioning/heat unit had two holes with the drywall cracked/missing. The wall to the right of the air conditioning/heat unit was scraped and missing paint in a section from the unit toward the wardrobe. The resident's over-bed light had cobwebs attached and hanging from the fixture. There were multiple areas of patched drywall near the restroom door and behind the room door that were white and without paint. The bedside table had missing veneer along the top edges with particleboard exposed. There was a

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hand-written note posted above the resident's bed dated 3/24/21 stating, "Wraps are not to be removed at night. (will be changed three times a week per wound nurse)."

On 6/22/21 at 11:50 a.m., Resident #21 was interviewed about the detached wardrobe door and room items in disrepair. Resident #21 stated he did not know what happened to the wardrobe door but it had been off the hinges for about two weeks. Resident #21 stated the restroom doorknob had been broken for "awhile" and made it difficult to open. Resident #21 stated he knew nothing about the hand-written note above the bed. Resident #21 stated the end of his bed was broken and someone had put tape on it.

On 6/22/21 at 11:52 a.m., Resident #21's bed footboard was inspected. The right side of the footboard frame was broken and detached from the bed frame. Black tape was applied to the broken frame joint. The footboard was loose and completely detached from the frame on the right side (when standing in room facing end of bed).

On 6/23/21 at 2:30 p.m., the licensed practical nurse (LPN #2) caring for Resident #21 was interviewed about the items in disrepair. LPN #2 stated there was a work order system used to report repair needs to maintenance. LPN #2 stated she was not aware of any recently submitted work orders regarding Resident #21's room or furnishings.

On 6/23/21 at 2:33 p.m., accompanied by the unit manager (LPN #3), Resident #21's room and furnishings were observed. LPN #3 was interviewed at this time about the items in disrepair. LPN #3 stated he saw the wardrobe

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| F 584 | Continued From page 19<br>door was off yesterday (6/22/21) and got maintenance to replace the door. LPN #3 stated he was not aware of the broken footboard or doorknob. LPN #3 stated the furniture was not in good condition as the dresser drawers were not easily opened/closed. LPN #3 stated when items needed repair a work order was entered and maintenance was responsible for fixing or replacing items. LPN #3 stated he did not know who posted the sign above the resident's bed about the lymphedema wraps or who taped the broken footboard.<br><br>On 6/23/21 at 3:45 p.m., the maintenance director (other staff #3) was interviewed about the condition of Resident #21's room and furnishings. The maintenance director stated he had received no prior work orders about repairs needed for Resident #21 and was not aware of the broken footboard. The maintenance director stated there was a long-range work order for painting and wall repair in the facility and they were concentrating on painting rooms when they were empty.<br><br>These findings were reviewed with the administrator and director of nursing during a meeting on 6/23/21 at 5:15 p.m. The administrator stated at this time they had recognized the poor condition of the furniture in the facility. | F 584 | | |
| F 636 SS=D | Comprehensive Assessments & Timing<br>CFR(s): 483.20(b)(1)(2)(i)(iii)<br><br>§483.20 Resident Assessment<br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. | F 636 | | |

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| F 636 | Continued From page 20<br><br>§483.20(b) Comprehensive Assessments<br>§483.20(b)(1) Resident Assessment Instrument.<br>A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:<br>(i) Identification and demographic information<br>(ii) Customary routine.<br>(iii) Cognitive patterns.<br>(iv) Communication.<br>(v) Vision.<br>(vi) Mood and behavior patterns.<br>(vii) Psychological well-being.<br>(viii) Physical functioning and structural problems.<br>(ix) Continence.<br>(x) Disease diagnosis and health conditions.<br>(xi) Dental and nutritional status.<br>(xii) Skin Conditions.<br>(xiii) Activity pursuit.<br>(xiv) Medications.<br>(xv) Special treatments and procedures.<br>(xvi) Discharge planning.<br>(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).<br>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.<br><br>§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this | F 636 | | |

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chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure a complete minimum data set (MDS) for two of 27 residents in the survey sample. MDS assessments for Resident #32 and #43 were incomplete with no indicators of cognitive status or mood.

The findings include:

1. Resident #43 was admitted to the facility on 6/6/20 with diagnoses that included chronic kidney disease, atherosclerotic heart disease, heart failure, diabetes, cellulitis, anemia, peripheral vascular disease, major depressive disorder, left eye blindness and peripheral neuropathy. The minimum data set (MDS) dated 3/5/21 assessed Resident #43 with moderately impaired cognitive skills, with little interests in doing things and having feelings of being down, depressed and/or hopeless.

Resident #43's clinical record documented an

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annual MDS dated 4/14/21. Sections C for cognitive patterns and section D for mood indicators were not completed. The interview questions and assessment indicators were marked as "not assessed" or marked with dashes.

On 6/23/21 at 3:25 p.m., the registered nurses (RN #1 and #2) responsible for MDS assessments were interviewed about Resident #43's incomplete MDS. RN #1 stated sections C and D were not completed on the 4/14/21 assessment. RN #2 stated the interviews and assessments required for sections C and D had to be done prior to or on the assessment reference date in order to be included on the MDS. RN #1 stated the interviews and assessments for Resident #43's annual MDS dated 4/14/21 were not done timely and caused the incomplete MDS.

The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (version 1.17.1) documents on page C-1 concerning assessment of cognitive status, "...The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions...Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood..." Page D-1 of the manual documents concerning mood assessment, "The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is

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associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable..." (1)

This finding was reviewed with the administrator and director of nursing during a meeting on 6/23/21 at 5:15 p.m.

(1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, Centers for Medicare & Medicaid Services, October 2019.

2. Resident # 32 was most recently readmitted to the facility on 12/12/2019 with diagnoses that included anemia, hypertension, renal insufficiency, diabetes mellitus, non-Alzheimer's dementia, anxiety disorder, depression, chronic obstructive pulmonary disease, gastroesophageal reflux disease, history of COVID-19, polyosteoarthritis, generalized muscle weakness, and insomnia.

Review of the resident's most recent Quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 4/28/2021, revealed that Section C (Cognitive Patterns) and Section D (Mood) were not completed.

At Section C (Cognitive Patterns), Item C0100 (Should brief interview for Mental Status be conducted) was answered "Yes." Items C0200 through C0400, and C0600 through C1000 were answered as "Not Assessed." Item C0500 was blank.

At Section D (Mood), Item D0100 (Should Resident Mood Interview be Conducted) was

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| F 636 | Continued From page 24<br>answered "Yes." Items D0200, D0500, and D0600 were answered as "Not Assessed." Item D0300 was blank.<br><br>At approximately 3:00 p.m. on 6/23/2021, RN # 1 (Registered Nurse) was asked about the incomplete information at Sections C and D on the resident's Quarterly MDS. RN # 1 indicated she would look into the matter. At approximately 4:45 p.m. on 6/23/2021, RN # 1 was asked again about the incomplete information at Sections C and D. RN # 1 said the sections were not done, but she did not know why. Asked who signed off on the MDS as it having been complete, RN # 1 said the person that the MDS was no longer employed.<br><br>At approximately 5:30 p.m. on 6/23/2021, during an end of day meeting that included the Administrator, Director of Nursing, and the survey team, Resident # 32's incomplete Quarterly MDS was discussed. | F 636 | | |
| F 657 SS=E | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff. | F 657 | | |

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(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 staff interview, clinical record review and facility document review, the facility staff failed to review and revise a care plan for four of 27 residents in the survey sample, and failed to ensure residents were extended an invitation to the care plan meetings and active participation from the facility's required interdisciplinary team members for two of 27 residents in the survey sample. Resident #24, Resident #75, and Resident #21 care plans were not reviewed and revised regarding code status changes and Resident #35's care plan was not reviewed regarding medication changes. Resident #94 and Resident #12 were not extended invitations to the care plans meetings and facility's required interdisciplinary team members did not actively participate in the care plan meetings.

The findings include:

1. Resident #24 was originally admitted to the facility on 05/22/2012 and readmitted on 06/14/201 with diagnoses that included dementia

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with behavioral disturbance, muscle contractures, anemia, hyperlipidemia, dysphasia, depression, hypokalemia, and unspecified psychosis. The most recent minimum data set (MDS) dated 4/3/21 was a quarterly assessment and assessed Resident #24 was severely impaired for daily decision making with a score of 2 out of 15

On 06/22/21, Resident #24's clinical record was reviewed. Observed on the physician order summary was the following: "Do not Administer CPR. Order Status: Active. Order Date: 07/29/2020. Observed on Resident #24's care plan was the following: ".....Code Status: Full Code [Resident #24] has end of life choices related to code status, living will. Dated Initiated: 06/15/2017. Revision on 06/15/2017...."

On 06/23/21 at 2:16 p.m., the social services director (OS #1) was interviewed regarding the code status change and who was responsible for updating the care plans with changes. OS #1 stated either herself and/or nursing were responsible for care plan revisions if there was a code status change. OS #1 stated nursing will write the new order and sometimes they will update the care plan otherwise she will update the care plan. OS #1 stated she would review the hard/paper chart to make sure [Resident #24] had a DNR (do not resuscitate) order on file.

A copy of the signed DNR form was provided by OS #1 which documented the code status change including the signatures of the physician and Resident #24's daughter/POA (power of attorney) on 7/29/2020. OS #1 stated this was during the time the facility was completing a code status audit and the care plan revision was missed.

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The above findings were discussed with the administrator and director of nursing during a meeting on 06/23/21 at 5:08 p.m.

2. Resident #75 was originally admitted to the facility on 01/13/2016 and readmitted on 08/07/2020 with diagnoses that included schizoaffective disorder, bipolar disorder, dysphasia, post traumatic stress disorder (PTSD), insomnia, anxiety disorder, borderline personality, depression and hypertension. The most recent minimum data set (MDS) dated 5/9/21 was a quarterly assessment and assessed Resident #15 as cognitively intact for daily decision making with a score of 15 out of 15.

On 06/22/21 Resident #75's clinical record was reviewed. Observed on the physician's order summary was the following: "....DNR (do not resuscitate). Order Status: Active. Order Date: 08/07/2020...." Observed on Resident #75's care plans was the following: "....[Resident #75] has an advance Directive as evidenced by: Full code. Date Initiated: 05/08/2018. Revision: 07/17/2020...."

On 06/23/21 at 2:16 p.m., the social services director (OS #1) was interviewed regarding the code status change and who was responsible for updating the care plans with changes. OS #1 stated either herself and/or nursing were responsible for care plan revisions if there was a code status change. OS #1 stated nursing will write the new order and sometimes they will update the care plan otherwise she will update the care plan. OS #1 stated she would review the hard/paper chart to make sure [Resident #75] had a DNR (do not resuscitate) order on file.

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A copy of the signed DNR form was provided by OS #1 which documented the code status change including the signatures of the physician and Resident #75's daughter on 8/7/2020. Hand written on the form was the following: "Patient is OK with intubation, no to CPR." OS #1 stated this was during the time the facility was completing a code status audit and the care plan revision was missed.

The above findings were discussed with the administrator and director of nursing during a meeting on 06/23/21 at 5:08 p.m.
3. Resident #21 was admitted to the facility on 2/26/16 with a re-admission on 10/3/19. Diagnoses for Resident #21 included right shoulder/hand contracture, spinal stenosis, dysphagia, hypertension, dementia with behaviors, congestive heart failure, lymphedema, seizures, osteoarthritis, cerebral infarction and neuropathy. The minimum data set (MDS) dated 4/1/21 assessed Resident #21 with moderately impaired cognitive skills.

Resident #21's clinical record documented a physician's order dated 3/22/21 for DNR/DNI (do not resuscitate/do not intubate) in case of cardiac or respiratory arrest. The record documented a Durable Do Not Resuscitate Order form dated 3/22/21 that was signed by the resident's representative and the physician.

Resident #21's plan of care (revised 2/18/21) was not revised to reflect the do not resuscitate status. The resident's care plan documented, "[Resident #21] has an advance Directive as evidenced by: Full Code" with interventions listed to perform cardiopulmonary resuscitation in case of cardiac or respiratory arrest.

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On 6/23/21 at 2:18 p.m., the facility's social worker (other staff #1) was interviewed about Resident #21's resuscitation status. The social worker stated the resident had a do not resuscitate order and the care plan had not been revised to reflect the change in code status.

On 6/23/21 at 2:43 p.m., the licensed practical nurse unit manager (LPN #3) was interviewed about Resident #21's code status. LPN #3 stated the resident's code status was changed to do not resuscitate in March 2021 and the care plan may not have been updated with the DNR status.

This finding was reviewed with the administrator and director of nursing during a meeting on 6/23/21 at 5:15 p.m.

4. Resident #94 was admitted to the facility on 2/26/19 with diagnoses that included chronic kidney disease with hemodialysis, schizoaffective disorder, psychosis, hypertension, chronic pain syndrome, history of COVID-19 and cognitive communication deficit. The minimum data set (MDS) dated 5/17/21 assessed Resident #94 as cognitively intact.

On 6/22/21 at 11:30 a.m., Resident #94 was interviewed about quality of care in the facility. Resident #94 stated during the interview he was not aware of a recent care plan meeting and did not recall an invitation to a meeting.

Resident #94's clinical record documented no care plan meeting since September 2020. A Care Conference Review sheet documented Resident #94's last care plan meeting occurred on 9/16/20. The care conference signature sheet

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documented the activities director and the unit manager as the only attendees. There was no evidence the resident had been invited to the conference and no documentation in the record indicating a resident refusal or any efforts made to include the resident in the meeting.

Resident #94's clinical record documented an annual review note by the social worker on 1/29/21 and a quarterly review note dated 3/30/21. There was no mention of a care plan meeting or any documented explanation about a care conference for Resident #94. The record documented MDS assessments dated 10/30/20, 1/30/21, 2/17/21 and 5/17/21. There were no care meetings associated with the MDS assessments.

On 6/24/21 at 10:40 a.m., the social worker (other staff #1) was interviewed about care plan reviews for Resident #94. After researching, the social worker stated Resident #94 had not had a care conference since around October 2020. The social worker stated she did not know why a conference had not been conducted. Concerning the last care plan meeting conducted on 9/16/20, the social worker stated, "He [Resident #94] may have been verbally invited but I don't have evidence of it." The social worker stated the unit manager and activities director might have been the only attendees at the 9/16/20 meeting. When asked why the other disciplines did not attend, the social worker stated, "I don't know. I can't answer that." The social worker stated the resident meetings should occur every three months.

These findings were reviewed with the administrator and director of nursing during a meeting on 6/24/21 at 12:30 p.m.

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5. Resident #12 was admitted to the facility on 12/28/19. Diagnoses for Resident #12 included: Congestive heart failure, kidney disease, anxiety, and depression. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/25/21. Resident #12 was assessed with a cognitive score of 15 indicating cognitively intact.

On 06/22/21 at 12:21 PM Resident #12 was interviewed. During the interview, Resident #12 was asked about being invited and attending care plan meetings. Resident #12 said she had not been invited or attended any care plan meetings.

On 06/23/21 at 9:41 AM, the social worker (SW) was interviewed regarding Resident #12's care plan meetings. The SW said, about a year ago the facility stopped sending out invitation letters and started calling responsible parties and having verbal care plan meetings to the residents. When asked how the SW could evidence that invitations were being done, the SW stated that she was not able to evidence invites were being done.

On 06/23/21 at 10:54 AM the SW, stated she was not able to find any invitations (for Resident #12) for a care plan meeting looking back a year.

On 6/23/21 SW progress notes along with care plan meeting sign off sheets were reviewed from March 2020 to present and indicated that Resident #12 was not in attendance at any care plan meetings. The sheets also indicated only the social worker, activities director, and unit manager were in the meetings. The SW progress notes also did not indicate what was discussed during the meetings and did not show any documentation for the reasoning for Resident

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#12 not attending.

On 06/23/21 at 05:07 PM the above information was presented to the administrator and director of nursing.

On 6/24/21 at 10:30 AM, the Social Worker did present a copy of a care plan sign in sheet dated 11/7/19 with Resident #12's signature. The SW was asked, why the necessary IDT (interdisciplinary team) representatives were not at the meetings (based on the care plan meeting signature sheet). The SW said "I don't know I can't answer that, but a schedule is sent to the departments."

A facility "Process for Care Plan meetings" was presented and read in part: "[...] 3. Social Services will be responsible to assure the care plan meeting invitation is completed and sent to the resident and responsible party. A copy of the letter is to be placed in the chart. [...] 6. The following team members will be present during the care plan meeting: A clinical representative, Dietary, Social Services, Activities, and Therapy. [...] 13. A care plan note must be created at the time of the meeting to include a brief discussion of the meeting, concerns, follow up, etc. [...]"

No other information was presented prior to exit conference on 6/24/21.

6. Resident #35 was admitted to the facility on 07/20/20, with the most current readmission on 01/29/21. Diagnoses for Resident #35 included, but were not limited to: muscle weakness, muscle wasting, atrophy, weakness, and chronic pain.

The most current MDS (minimum data set) was a

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| F 657 | Continued From page 33<br>quarterly assessment dated 04/11/21. This MDS assessed the resident with a cognitive status of 15, indicating the resident was intact for daily decision making skills.<br><br>During an interview with Resident #35 on 06/22/21 at approximately 11:00 AM, the resident was asked if he had pain concerns. Resident #35 stated that he really didn't have much pain and stated that he gets scheduled pain medications [by mouth] and that probably helps with him not having pain.<br><br>Resident #35's CCP was reviewed "...[date initiated: 11/05/2020] is resistive to care related to refusing Lidocaine patch per orders...allow to make decisions about treatment regimen..."<br><br>Resident #35's physician's orders were reviewed. There were no physician's order for a Lidocaine patch.<br><br>Further review of the resident's record revealed the Lidocaine patch had been discontinued on 01/25/21.<br><br>On 06/23/21 at approximately 3:00 PM, the DON (director of nursing) was made aware that the care plan had not been reviewed and revised regarding this medication. The DON stated that MDS makes care plan changes, as well as nursing and that his may not have been updated because the resident had went out to the hospital, but wasn't sure.<br><br>No further information was presented prior to the exit conference on 06/24/21. | F 657 | | |
| F 685 SS=E | Treatment/Devices to Maintain Hearing/Vision | F 685 | | |

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| F 685 | Continued From page 34<br>CFR(s): 483.25(a)(1)(2)<br><br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, and clinical record review, the facility failed to ensure glasses were ordered to maintain vision for two of 27 residents, Resident's #12 and #94.<br><br>The Findings Include:<br><br>1. Resident #12 was admitted to the facility on 12/28/19. Diagnoses for Resident #12 included: Congestive heart failure, kidney disease, anxiety, and depression.<br><br>The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 3/25/21. Resident #12 was assessed with a cognitive score of 15 indicating cognitively intact. Section "B" of the current MDS documented Resident #12's vision was adequate with corrective lenses.<br><br>On 06/22/21 at 12:21 PM. Resident #12 was | F 685 | | |

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interviewed. During the interview, Resident #12 discussed that she had an eye exam about a year ago and she was supposed to receive new glasses but never did get them. Resident #12's glasses were observed to have scratches on the lenes only one ear piece.

On 06/23/21 at 9:41 AM, the social worker (SW) was interviewed regarding Resident #12's eye glasses. The SW said the eye doctor had been coming to the facility but had stopped during the COVID pandemic and has recently started coming back to the facility. The SW stated she would check and see if Resident #12 had been seen by the eye doctor during the past year. The SW was asked to also check to see if a Medicaid adjustment had been completed to help pay for the glasses.

On 06/23/21 at 10:54 AM, the SW said she had talked with Resident #12 earlier in the morning regarding glasses and Resident #12 wanted some glasses. The SW said she did not observe the state of Resident #12's current glasses. The SW also said that she checked with business office to see if an adjustment had been made to pay for glasses but it had not.

On 06/23/21 at 11:57 AM, the SW provided documentation that Resident #12 had been seen by the facility optometrist on 12/4/19 and had been prescribed bifocal glasses and said they never got ordered. The SW also said that she talked with Resident #12 again and let Resident #12 know that the eye doctor will be in the facility within a week and Resident #12 agreed to be put on he list to be seen again. The SW said after the optometrist comes in the proper paper work will be completed to have the glasses ordered

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and paid for.

On 06/23/21 at 05:07 PM, the above information was presented to the administrator and director of nursing. No other information was presented prior to exit conference on 6/24/21.

2. Resident #94 was admitted to the facility on 2/26/19 with diagnoses that included chronic kidney disease with hemodialysis, schizoaffective disorder, psychosis, hypertension, chronic pain syndrome, history of COVID-19 and cognitive communication deficit. The minimum data set (MDS) dated 5/17/21 assessed Resident #94 as cognitively intact.

On 6/22/21 at 11:30 a.m., Resident #94 was interviewed about quality of care and life in the facility. When asked about any vision problems, Resident #94 stated he had been to an eye doctor since his admission and was told he needed prescription glasses. Resident #94 stated the eye exam had been months ago and he had never received any glasses or further information about the glasses. Resident #94 stated he had blurry vision especially with near vision.

Resident #94's clinical record documented the resident was evaluated by a local ophthalmologist on 8/27/19. The ophthalmologist's progress note dated 8/27/19 documented, "Patient states that his vision is pretty blurry at times and has a real hard time looking at small print...Lost glasses 4 - 5 years ago, and since then has had trouble with vision, especially at near." The physician diagnosed presbyopia and provided a glasses prescription that was attached to progress note.

The clinical record documented a nursing note

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| F 685 | Continued From page 37<br>dated 8/27/19 stating, "Resident returned from appoint [appointment] with prescription for glasses..."<br><br>On 6/24/21 at 11:18 a.m., the social worker (other staff #1) was interviewed about why the resident had not been assisted with obtaining prescription glasses since the 2019 eye doctor visit. The social worker stated she was not informed the resident had been to the eye doctor or that he needed prescription glasses. The social worker stated Resident #94 went outside the facility to a local eye doctor and nursing made arrangements for those type of visits. The social worker stated if she had been informed about the prescription, resources were available to obtain the glasses.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/24/21 at 12:30 p.m. | F 685 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced | F 686 | | |

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by:
Based on observation, staff interview and facility document review, the facility staff failed to ensure necessary care and treatment to prevent infection during a dressing change for one of 27 residents (Resident #35).

Findings include:

Resident #35 was admitted to the facility on 07/20/20, with the most recent readmission on 01/29/21. Diagnoses for Resident #35 included, but were not limited to: muscle weakness, muscle wasting, atrophy, weakness, chronic pain, diabetes, heart failure and stage 4 pressure ulcer.

The most current MD (minimum data set) was a quarterly assessment dated 04/11/21. This MDS assessed the resident with a cognitive status of 15, indicating the resident was intact for daily decision making skills. This MDS also assessed the resident with a stage 4 pressure ulcer that was present upon admission.

During an interview with Resident #35 on 06/22/21 at approximately 11:00 AM. Resident #35 was asked about his pressure ulcer. The resident stated that was what brought him into the facility and that he has had it for a long time and it was present on admission.

On 06/23/21 at 8:20 AM, the wound physician was observed debriding the resident's wound. Resident #35 was rolled over on his right side. The resident had a chuck pad laying on the back side on the bed at his buttocks. The physician cleaned and debrided the wound and discarded the soiled gauzes onto the chuck pad. LPN (Licensed Practical Nurse) #5 and LPN #6

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prepared to apply a new dressing to the stage 4 pressure area. A gnat was flying around the area and the physician waved his hand to get the gnat away from the resident. LPN #5 was assisting LPN #6 with the dressing change. LPN #5 was holding Resident #35 on his right side and was handing supplies to LPN #6 as needed. LPN #6 used hand sanitizer, applied gloves and went to the area where the chuck pad was with the soiled cleaning supplies from the debridement/cleaning. LPN #6 gathered up the soiled cleaning materials, discarded in the trash, removed his gloves, used hand sanitizer and applied a new pair of gloves. A used glove was laying on the bed. LPN #6 picked up the used glove with his gloved hand and put it in a trash bag that was laying at the bottom of the resident's bed. LPN #6 preceded to take a dressing material and place it in the resident's wound, pushing it in with a sterile Q-tip and pushing the edges with his gloved finger. LPN #6 took another type of dressing material from LPN #5 and put that into the wound bed. LPN #5 stated, "Now take your gloves off and wash up." LPN #6 took off the gloves and again used hand sanitizer. LPN #6 put on a new pair of gloves, placed an ABD pad over the wound dressing and covered with an adherent dressing. LPN #6 took off his gloves and washed his hands with soap and water. LPN #6 came back to the bed side to dress another smaller wound. LPN #6 was made aware that a gnat landed on the bottom of the resident's bed. LPN #6 waved his hand in an effort to get rid of the gnat, without success, then LPN #6 then took his hand and brushed the bed quickly to get the gnat off the bed. LPN #6 applied gloves without washing or sanitizing, and proceeded to cleanse the smaller wound and then dressed the wound.

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At the completion of the dressing change. LPN #5 and LPN #6 were asked about the procedure for hand washing and glove changes. LPN #5 stated that he wasn't sure if when packing a wound if the hands had to be cleaned with soap and water or if hand sanitizer was ok, and stated he wasn't sure what the policy said. LPN #6 stated that he should have washed his hands after he brushed the bed with his hand to get the gnat off the bed and when he picked up the used glove off the bed.

On 06/23/21 at approximately 10:15 AM, the DON (director of nursing) was asked for a policy and procedure on dressing changes, hand washing and glove changing.

A "competency" simple wound dressing change was presented and documented, "...obtain supplies...perform hand hygiene...don gloves and remove old dressing-discard in trash...remove gloves and perform hand hygiene without turning back to work area...don gloves-cleanse wound...apply medications with applicators...secure dressing...remove gloves and perform hand hygiene.."

A standard precautions policy was presented and documented, "...Hand Hygiene...Two Techniques for hand hygiene 1. Alcohol-based Hand Sanitizer...2. Handwashing with soap and water...When to perform hand hygiene..before and after direct contact with a resident's skin...wound dressings...after glove removal..."

No information on glove changing was provided. No further information and/or documentation was presented prior to the exit conference on 06/24/21.

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| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>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.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§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<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on medication pass observation, staff interview, and clinical record review, the facility failed to ensure medications were available for one of 27 residents, Resident #61. Resident #61 | F 755 | | |

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did not have Lactulose solution (for treatment of constipation and liver disease) available to give during the morning medication pass.

The findings include:

Resident #61 was admitted to the facility on 7/9/19 with a readmission on 4/21/21. Diagnoses for Resident #61 included: Chronic obstructive pulmonary disease, schizoaffective disorder, chronic kidney disease, viral hepatitis C, and constipation. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/1/21. Resident #61 was assessed with a cognitive score of 12 indicating cognitively intact.

On 6/23/21 at 8:10 AM, during medication pass and pour, license practical nurse (LPN #1 ) began pulling medications for Resident #61. LPN #1 said Resident #61's Lactulose was not on the cart and was going to check in the medication room to see if pharmacy had delivered it. LPN #1 came back and said that the medication had not been delivered.

LPN #1 then explained to the nurse practitioner that Resident #61's lactulose was not delivered. The nurse practitioner gave an order to hold the medication until it arrived.

LPN #1 stated that the pharmacy comes twice daily, early in the morning and again in the evening.

On 6/23/21 Resident #61's medication order for Lactulose was reviewed and documented "Lactulose Solution 10 GM [gram]/15 ML [Milliliter] Give 30 ml by mouth three times a day for acities.

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| F 755 | Continued From page 43<br>The times of the medication to be given were 8:00 AM, 12:00 PM, and 5:00 PM.<br><br>On 6/23/21 at 11:10 AM, LPN #1 stated that the Lactulose had been delivered by the alternate pharmacy and was going to be given.<br><br>On 06/23/21 at 5:07 PM, the above information was presented to the administrator and director of nursing.<br><br>No other information was presented prior to exit conference on 6/24/21. | F 755 | | |
| F 800 SS=D | Provided Diet Meets Needs of Each Resident<br>CFR(s): 483.60<br><br>§483.60 Food and nutrition services.<br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to implement food preferences for two of 27 in the survey sample, Resident #109 and Resident #481.<br><br>The findings include:<br><br>1. Resident #109 was admitted to the facility on 05/21/21 with diagnoses that included paraplegia, surgical wound aftercare, osteomyelitis, multiple pressure wounds, muscle weakness, anemia, Vitamin B-12 deficiency, and embolism and thrombosis of veins. The most recent minimum | F 800 | | |

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data set (MDS) dated 05/28/21 was the admission assessment and assessed Resident #109 as cognitively intact for daily decision making with a score of 15 out of 15.

On 06/22/21 at 12:28 p.m., Resident #109 was observed in his room watching television. Resident #109 was interviewed regarding his quality of care since being admitted to the facility. Resident #109 stated, "one of my biggest issues is the food, I believe it could be better." Resident #109 was about his food and dining preferences. Resident #109 stated, "the food can be cold sometimes but they will reheat it. They offer us different alternatives and choices but you rarely get what you ask for." Resident #109 was asked if anyone had discussed his food preferences with him since his admission. Resident #109 stated, "no, not that I remember." Resident #109 was asked how he was able to make alternative meal choices. Resident #109 stated, "we get a daily menu sheet that we fill out and turn back in to the nurses and I guess they turn it into the kitchen. But you rarely get what you ask for. It doesn't make sense to offer alternatives, but we can never get them." Resident #109 was asked if he received snacks. Resident #109 stated, "again, there is no need to ask or request them because you either won't get what you ask for or you won't get anything at all."

On 06/22/21, Resident #109's clinical record was reviewed. Observed was the Dietary Nutritional Assessment completed by the dietitian on 05/28/21. Under Section B - Food Nutrition Related History - #11 Food preferences on record - was documented as "No". Observed within the clinical record was the Resident Preference Evaluation completed by the activities manager

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on 05/25/21. Under Daily Preferences - #4 How important is it to you to have snacks available between meals was documented "very important". The form documented Resident #109's snacking preferences times as between breakfast and lunch, between lunch and dinner and PRN (as needed/requested). The form documented Resident #109's daily preferences as "enjoying drinks more than snacks."

On 06/23/21 at 2:45 p.m., the dietary manager (OS #2) was interviewed regarding how and when food preferences were discussed with residents. OS #2 stated, "I have not been doing them on time." OS #2 was asked about the timeframe to complete the preferences, and he stated 48 hours of admission. OS #2 was asked why was there a delay in completing the new admission dietary preference interviews. OS #2 stated, "I've been busy and working long hours and just got behind." OS #2 was asked if the dietary department provided snacks. OS #2 stated, "yes, dietary provides snacks 3 times a day and residents can request items with their preferences interview." OS #2 also stated the activities department provides a snack cart one to two days per week. OS #2 was asked if the facility provided fresh fruits. OS #2 stated, "yes we have bananas and oranges available." OS #2 was asked how did residents make changes or select alternative meal choices. OS #2 stated, "each day the residents are given a daily news gazette from the activities department which also includes a menu for the next day and they are able to make alternative choices from the items listed on the menu and the form must be turned in by 9 a.m. the next day for any alternative selections to be made with lunch and/or dinner." OS #2 was asked if he entered the food

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preferences information into the electronic clinical record. OS #2 stated, "no I don't have access to the [electronic clinical record]. I enter the information into the dietary meal tracker system. OS #2 was asked when did he complete Resident #109's the food preferences interview and enter the info into the meal tracker system. OS #2 stated, "to be honest I don't remember."

A review of Resident #109's food preferences interview was reviewed. The form was 2 pages and included various categories for breakfast, lunch and supper food preferences and drink/beverage preferences, admission information, diet order, food allergies, food intolerance, ethnic/religious preferences, and snack preferences. The form documented Resident #109's name and the boxes for "broccoli and canned tuna" were checked. There was no additional information completed on the form to indicate Resident #109's preferences and/or dislikes and dietary needs.

On 06/23/21 at 3:30 p.m., the activities manager (OS #4) was interviewed regarding snacks being provided to the residents. OS #4 stated the activities department provided a snack cart to the residents one to two days a week depending on activity schedule.

The above findings were shared with the administrator and director of nursing during a meeting on 06/23/21 at 5:08 p.m.

2. Resident #481 was admitted to the facility on 06/11/21 with diagnoses that included paraplegia, colostomy, hypothyroidism, intestinal bypass, depression, anemia, and conversion disorder with seizures. The most recent minimum data set

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(MDS) dated 6/15/21 was the 5 day assessment and assessed Resident #481 as cognitively intact for daily decision making with a score of 15 out of 15.

On 06/22/21 at 12:45 p.m., Resident #481 was interviewed regarding the quality of care since her admission to the facility. Resident #481 stated, "the food isn't good. They provide us with a list of bistro items to select from and when you choose the items you want you never get what you selected. I have a urostomy and colostomy and require fruits and veggies to help me with bowel movements. I request a salad with each meal and rarely get them. It just doesn't make sense. I get so gassy with all of these heavy food items. It seems like there are some form of onions included in everything and they don't work with my condition. I don't understand why I can't get some fruits and veggies more often. Last week I had to ask a friend to bring me fresh bananas to have here in my room because the facility was out of bananas. I also don't get snacks in the afternoon or in between meals. I enjoy chips and I don't think it's too much to ask to receive a salad, some bananas and some chips." Resident #481 was asked if anyone had discussed her food preferences with her since admission. Resident #481 stated, "no one has been in here to ask me anything. When I get something I don't won't or like or if it isn't what I selected on my menu sheet I just tell one of the staff and they notify the kitchen and eventually I get something else."

On 06/22/21, Resident #481's clinical record was reviewed. Observed within the clinical record was the Resident Preferences Evaluation completed on 06/15/21 by the activities manager. Under Daily Preferences - #4 How important is it to you

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to have snacks available between meals was documented "very important". The form documented Resident #481's snacking preferences times as between lunch and dinner, Evening/HS (bedtime) and PRN (as needed/requested). The form documented Resident #481's daily preferences as snacks: chips, peanut butter crackers, fresh fruit, bananas and apples...."

On 06/23/21 at 2:45 p.m., the dietary manager (OS #2) was interviewed regarding how and when food preferences were discussed with residents. OS #2 stated, "I have not been doing them on time." OS #2 was asked what was the timeframe to complete the preferences and he stated 48 hours of admission. OS #2 was asked why was there a delay in completing the new admission dietary preference interviews. OS #2 stated, "I've been busy and working long hours and just got behind. OS #2 was asked if the dietary department provided snacks. OS #2 stated, "yes, dietary provides snacks 3 times a day and residents can request items with their preferences interview." OS #2 also stated the activities department provides a snack cart one to two days per week. OS #2 was asked if the facility provided fresh fruits. OS #2 stated, "yes we have bananas and oranges available." OS #2 was asked if there had been a problem with keeping bananas in stock. OS #2 stated, "we were out of bananas one day last week due to a shipping delay." OS #2 was asked how did the residents make changes or select alternative meal choices. OS #2 stated, "each day the residents are given a daily news gazette from the activities department which also includes a menu for the next day and they are able to make alternative choices from the items listed on the

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menu and the form must be turned in by 9 a.m. the next day for any alternative selections to be made with lunch and/or dinner." OS #2 was asked if he entered the food preferences information into the electronic clinical record. OS #2 stated, "no I don't have access to the [electronic clinical record]. I enter the information into the dietary meal tracker system. OS #2 was asked when did he complete Resident #481's the food preferences interview and enter the info into the meal tracker system. OS #2 stated, "to be honest I don't remember."

A review of Resident #481's food preferences interview was reviewed. The form was 2 pages and included various categories for breakfast, lunch and supper food preferences and drink/beverage preferences, admission information, diet order, food allergies, food intolerance, ethnic/religious preferences, and snack preferences. The form documented Resident #481's name and the boxes for "prune juice, oatmeal and cold cereal, and spinach" were checked. Observed handwritten on the form was the following: "no onions, not a fan of bread, wants chips." There was no additional information completed on the form to indicate Resident #481's preferences and/or dislikes and dietary needs.

On 06/23/21 at 3:30 p.m., the activities manager (OS #4) was interviewed regarding snacks being provided to the residents. OS #4 stated the activities department provided a snack cart to the residents one to two days a week depending on activity schedule.

A review of the Food Preferences policy (May 2014) documented the following...."2. The Food

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| F 800 | Continued From page 50<br>Services Director or designee will complete a Food Preference Interview within 72 hours of admission for purpose of identifying food and beverage preferences...."<br><br>The above findings were shared with the administrator and director of nursing during a meeting on 06/23/21 at 5:08 p.m. | F 800 | | |
| F 925 SS=E | Maintains Effective Pest Control Program<br>CFR(s): 483.90(i)(4)<br><br>§483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to ensure effective pest control in the facility for two resident rooms on the 400 unit (room 406 and 413), and in the hallway on the 400 unit, where gnats were observed; and failed to ensure effective pest control for flies and gnats observed in room 117 and 120 and 100 unit area.<br><br>Findings include:<br><br>Resident #35 (a resident with a cognitive score of 15) was interviewed on 06/22/21 at approximately 11:00 AM. The resident had his bedside table over him with a banana peel laying on the table. Several gnats were observed on the banana peel. Resident #35 was made aware of the gnats. The resident stated, "Where?" Resident #35 stated that he couldn't see very well and that he had poor vision and couldn't see the gnats.<br><br>On 06/23/21 at 8:20 AM, Resident #35 was | F 925 | | |

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observed for a dressing change. The resident's physician was in the room performing a debridement of the resident's wound. Gnats were observed flying in the area of the resident. LPN (licensed practical nurse) # 5 was asked about the gnats in the room. LPN #5 stated, "I don't like it." After the physician completed the debridement of the wound a gnat was observed flying in the area. The physician waved his gloved hand to remove the gnat from the area.

Towards the end of the dressing change for Resident #35, a gnat landed on the bottom of the resident's bed. The gnat was pointed out to LPN #6 who stated, "eww" and brushed the bed with his hand to the get the gnat off the bed and out of the area.

On 06/23/21 at 8:00 AM, Resident #116 [a resident with short and long term memory impairment and severe impairment in daily decision making skills] was observed sitting across from the nursing station. Resident #116 had a bedside table in front of her, with her breakfast uncovered. A peeled [uneaten] banana was laying on the tray with gnats observed on the banana.

Resident #114 [a resident with a cognitive score of 15] was standing at the nurse's station and commented that the gnats "are allover".

On 06/23/21 at approximately 10:45 AM, Resident #10 [a resident with a cognitive status of 15] was interviewed in her room. Several gnats were observed flying around in the resident's room between the resident's bed and the window. Resident #10 was asked if there was a problem with gnats. The resident stated, "Yes, there are

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plenty of gnats and flies."

06/23/21 03:45 PM, the maintenance director was interviewed regarding pest control, specifically for gnats and flies and was asked if he was aware, and had this been reported to him.

The maintenance director stated, "We've [maintenance department] been contacted for the drain flies and gnats and it's been reported to [name of pest control company] and has been treated with a certain chemical." The maintenance director stated that the pest control company was using the strongest treatment they could, but couldn't use certain kinds in the patient areas. The maintenance director stated that they were last in the facility on 06/22/21. The maintenance director stated that they come every other Tuesday and that it's an ongoing battle and again stated that [name of pest control company] was using the most potent chemical that they could in resident areas. The maintenance director stated that they did not have an operating air curtain in the facility and did not have any type of lights or other treatment interventions for pest control. The maintenance director stated that he was first made aware of the problem about four weeks ago. The maintenance director stated that he he started working a tthe facility on May 7, and had been at the facility for about 6 or 7 weeks. The maintenance director was not sure if this had been an issue prior to him, but stated that he would try to locate information regarding pest control.

06/24/21 10:07 AM, the maintenance director presented pest control records from January 2021 through 06/22/21. There was no indication in any of the records of what types of pests were

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being treated inside the facility. The records did not evidence that there had been any reported sightings from the facility staff to the pest control company or that the facility had requested treatment for gnats or flies for specific locations, such a resident rooms. The pest control records documented, "Activity - Dead Treatment rendered..." with the dates of 03/22/2019 and 04/05/2019. This was consistent documentation from January through June 2021. The maintenance director stated, that the facility was "planning to go with another pest control company" due to having had proven better results by other companies in other buildings.

On 01/12/21 a pest control log documented, "...inspected/treated perimeter for pest activity...window frames, exterior bait station...door frames, doorway...foundation...perimeter only...observation: Flies (kitchen/dining) Status: Pending Responsibility: Customer [facility] Date entered: 09/06/2017..."

On 01/19/21 a pest control log documented, "...Covid cases inside...Covid 19 precautions...Bait stations inspection, perimeter only...Observation: Door Sweep Needed Recommendation: Add/Repair Door Sweep Status: Pending Responsibility: Customer Date Entered: 11/07/18...Flies (kitchen/dining) Status: Pending Responsibility: Customer [facility] Date entered: 09/06/2017..."

On 02/08/21 a pest control log documented, "...Covid precautions...Bait stations inspection, perimeter only...Observation: Door Sweep Needed Recommendation: Add/Repair Door Sweep Status: Pending Responsibility:

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Customer Date Entered: 11/07/18...Flies (kitchen/dining) Status: Pending Responsibility: Customer [facility] Date entered: 09/06/2017..."

On 2/15/21 and 03/01/21 pest control logs documented: "...Covid precautions...Bait stations inspection, inspected equipment...fly light inspected...treated bathrooms, inspected/treated common areas...kitchen...office areas...Observation: Door Sweep Needed Recommendation: Add/Repair Door Sweep Status: Pending Responsibility: Customer Date Entered: 11/07/18...kitchen/dining) Status: Pending Responsibility: Customer [facility] Date entered: 09/06/2017..."

03/10/21 documented, "...inspected/treated breakroom, inspected patient care area...Observation: Door Sweep Needed Recommendation: Add/Repair Door Sweep Status: Pending Responsibility: Customer Date Entered: 11/07/18...Flies (kitchen/dining) Status: Pending Responsibility: Customer [facility] Date entered: 09/06/2017..."

No other pest control logs or documentation was presented to evidence that an effective pest control system was in place for the prevention and/or treatment of gnats and flies.

The administrator and DON (director of nursing) were made aware in meeting with the survey team on 06/23/21 at 5:45 PM and again on 06/24/21 at 11:15 AM.

No further information and/or documetnation was presented to evidence that an effective pest control system was in place.
2. On 6/22/21 at 12:15 p.m., Resident #43 was

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observed in bed with his legs out of the bed covers. Four flies and several gnats were observed flying about the room and landing on the resident's sheets, leg, and snack items stored in a nearby chair.

On 6/22/21 at 12:41 p.m., flies and gnats were observed again in Resident #43's room. Resident #43 stated at this time that flies were in his room frequently and he had reported the flies to the nurses. Resident #43 stated he had to "cover up" with the sheet to keep the flies off him.

On 6/23/21 at 2:46 p.m., several flies and gnats were observed in Resident #43's room landing on the bed sheets, stored snack items and furniture in the room.

On 6/23/21 at 10:30 a.m., the certified nurses' aide (CNA #2) caring for Resident #43 was interviewed about the flies and gnats. CNA #2 stated flies were in Resident #43's room yesterday (6/22/21) and she had seen them before in the room. CNA #2 stated she had not reported the flies but frequently encountered them in Resident #43's room.

On 6/23/21 at 4:00 p.m., the maintenance director (other staff #3) was interviewed about the flies/gnats observed in resident rooms. The maintenance director stated flies and gnats had been reported and the contracted exterminator came once every two weeks for treatments. The maintenance director stated the exterminator was using the most powerful chemical allowed in the resident areas but it had not been effective in eliminating the pests. The maintenance director described the flies/gnats as an "ongoing battle" and efforts to date had been ineffective. The

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| F 925 | Continued From page 56<br>maintenance director stated there were no operating air curtains in the facility and the air curtain installed near the kitchen/laundry entrance was out of service. The maintenance director stated he had not had time to troubleshoot the inoperable air curtain.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 6/24/21 at 12:30 p.m. | F 925 | | |