Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35961056	A. BUILDING: _____ B. WING _____	01/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER BALDWIN PARK	2653 LAKE BALDWIN LANE ORLANDO, FL 32814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS A re-licensure survey was conducted from [redacted] to [redacted]. Westminster Baldwin Park had deficiencies found at the time of the visit.	N 000		
N 054 SS=E	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer [redacted] medication according to physician ordered parameters for 1 of 5 residents reviewed for unnecessary medications, (#11); and failed to follow physician orders for [redacted] treatment for 1 of 1 resident reviewed for non-pressure skin conditions, (#12), out of a total sample of 26 residents. Findings: 1. Resident #11 was admitted to the facility on [redacted] with diagnoses including [redacted] and [redacted]. Review of the Minimum Data Set (MDS) admission assessment with assessment reference date of [redacted] revealed resident #11 had medically [redacted] conditions. Review of the "Order Summary Report" for [redacted] revealed resident #11 had a physician order for [redacted] 10 milligrams (mg) to be given two times a day for	N 054	1. Resident # 11 was assessed by nurse and ARNP on [redacted] with no adverse effects noted to resident□s health and treatment orders were reviewed for resident #12 and new orders obtained from ARNP on [redacted]. 2. Other current resident□s with medication containing parameters were identified and administration documentation reviewed on [redacted]/2022. Residents who were given medications outside of parameters were assessed by nurse managers with no adverse effects noted, physicians were notified and no new orders were received. Full house skin check was completed on [redacted] on current residents. Treatment orders were reconciled with results of full house skin check along with a visual check to ensure ordered treatment was in place. No other discrepancies were noted. 3. DON/designee to re-educate nurses on medications that contain parameters to hold administration of medication, and appropriate documentation of holding	

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N 054	Continued From page 1 . The order included parameters to hold the medication if resident #11's rate was less than (bpm). is a medication which slows the rate and decreases , and the workload of the . This medication requires and rate to be checked as ordered by the physician. Adverse reactions could include , drowsiness, fatigue, low and (retrieved on from www.drugs.com). Review of the Medication Administration Record (MAR) for and , revealed over a 27-day period in facility, five nurses administered to resident #11 outside of specified parameter. Documentation showed resident #11 received this medication on 9 days although his rate was less than . The medication was administered on with a , on with a , on with a , on with a , on with a , on with a , on with a , and on with a . On , although resident #11's , his scheduled dose of was held despite a rate within parameter. Review of "Progress Notes" for and revealed no associated documentation for the above dates to explain why the was given and held for rate outside of the physician ordered parameter. On at 5:20 PM, the Director of Nursing	N 054	medication. DON/designee to re-educate licensed nurses on completing treatment orders as ordered by physician. 4. Biweekly audits will be completed by DON/designee for compliance in holding medications based on parameters x 3 months. Weekly audits to be completed by DON/designee x 3 months on compliance with treatment orders being completed as ordered. NHA/designee to present results of weekly audits in monthly QAPI x 3 months for compliance or need for changes or extension beyond 3 months to POC if indicated.	

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N 054	Continued From page 2 (DON) reviewed resident #11's MAR and confirmed that doses of , were not held according to parameter. She confirmed the medication should have been held as it could further lower the rate. The DON explained nurses were expected to check residents' vital signs at the bedside prior to administering medications and should only administer medications according to physician orders. On at 10:59 AM, Registered Nurse (RN) B confirmed she held resident #'11's , on . She confirmed the medication should have been given as ordered as his rate was above , . RN B acknowledged she administered , on when it should have been held due to a low rate. RN B said, "You don't want to administer the medication if rate is less than 60 because the medication will drop the rate even lower." On at 11:22 AM, Licensed Practical Nurse (LPN) C/Nursing Supervisor confirmed she administered resident #11's , on three occasions when it should have been held. She reviewed the medical record and acknowledged it was an error. On at 11:35 AM, the DON stated the facility's consultant pharmacist reviewed all medication once monthly. She stated the consultant pharmacist did not note any irregularities related to resident #11's , . Review of the "Consultant Pharmacist's Medication Regimen Review" for , revealed no recommendations for Resident #11. On at 1:05 PM, in a telephone interview	N 054		

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N 054	Continued From page 3 with the consultant pharmacist, she stated she periodically spot-checked medications with parameters during her monthly audits. The consultant pharmacist explained physician's ordered parameter for , was to ensure the medication would be held if the rate was too low. She confirmed administration of this medication outside the parameter could be dangerous. The facility's policy and procedure for "Medication Administration" dated , included guidelines to ..."8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters." Review of the job description for "Licensed Practical Nurse" dated , revealed essential job functions included, "Ensure that residents are receiving their medication based on doctor's orders/complete medication pass." Review of the job description for "Registered Nurse" dated , revealed the RN would provide direct nursing care. Review of the "Facility Assessment" tool revised revealed the facility would admit residents with / which included , and . The document indicated staff were trained annually on "Medication Administration." 2. Resident #12 was admitted to the facility on with diagnoses including prurigo nodularis, a skin condition associated with and severe itching (retrieved	N 054		

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N 054	Continued From page 4 from www.nih.gov). Review of the MDS significant change in status assessment with assessment reference date of [redacted] revealed resident #12 had a [redacted] score of 8 which indicated she had moderate [redacted]. The document revealed the resident did not exhibit any behavioral symptoms including rejection of care. The assessment indication resident #12 had skin conditions including [redacted] which required [redacted]. A care plan for at risk for altered skin integrity was initiated on [redacted]. Interventions included follow facility protocols for treatment of injury; monitor for and document location, size and treatment of skin injury, and report abnormalities to physician. The care plan directed nurses to perform [redacted] care and apply [redacted] treatments to the residents left anterior [redacted] as ordered. Review of resident #12's medical record revealed a physician order dated [redacted] to cleanse the left anterior [redacted] with normal [redacted] dry and apply Medi-honey and foam [redacted] daily and as needed. Review of the Treatment Administration Record (TAR) for [redacted] revealed nursing documentation to validate resident #12's [redacted] treatment was applied as ordered. Review of a " [redacted] Evaluation & Management Summary" dated [redacted] revealed resident #12's left anterior [redacted] was resolved on [redacted]. However, review of "Weekly Skin Inspection" forms dated [redacted] and indicated resident's skin was not intact but the areas noted were not new. A form dated	N 054		

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N 054	Continued From page 5 revealed resident #12's skin was intact. On . . . at 11:46 AM, during observation of resident #12's left lower ⌄ with LPN C, she confirmed there was an area of redness and that was warm to the touch. There were two scabbed areas above the resident's ankle that were each approximately one centimeter in diameter. The area of redness around the scabbed areas was ten centimeters wide and covered the circumference of her lower ⌄. There was no ⌄ in place. On at 12:01 PM, LPN C stated she was assigned to care for resident #12 on Monday, . She confirmed the resident's left lower ⌄ had been red and . on that day. LPN C acknowledged the change in the resident's condition of her ⌄ was significant and should have been reported to the physician. She acknowledged she had not completed any change in condition documentation nor notified the physician and the family. On . . . . at 12:22 PM, the DON assessed resident #12's left lower ⌄ and validated the presence of redness and . She confirmed the condition of the resident's ⌄ should have been identified by all staff assigned to the resident and reported to the physician. There was no . . . . . ⌄ in place. On ..... at 11:13 AM, resident #12's left lower ⌄ remained red and . There was no . . . . . ⌄ noted as directed by the plan of care. On at 4:25 PM, resident #12's assigned nurse, RN D stated he was aware of a on the resident's left lower ⌄. He stated he applied	N 054		

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N 054	Continued From page 6 ordered treatment to the area during the evening shift. Review of the TAR with RN D revealed a physician order scheduled for 4:00 PM daily and as needed. Observation of resident #12's with RN D revealed there was still no in place. Resident #12 stated nurses applied sometimes. She said, "If they put a small one on, it off by itself. If they put a large one, sometimes it stays." On at 4:33 PM, the DON was informed there was a treatment order for resident #12. She expressed surprise and stated she was not aware of any active treatment orders. She stated during a discussion with the Advanced Practice Registered Nurse (APRN) yesterday, she stated she no longer wanted a applied to the area. The DON was informed during observation on and , resident #12 did not have a in place. The DON confirmed the new order to discontinue the treatment was never transcribed to the medical record. On at 5:02 PM, the DON stated she contacted RN B who documented application of for resident #12 on 4 days the previous week. And RN B informed her she did not recall doing a . Review of the job description for "Licensed Practical Nurse" dated , revealed the LPN's essential job functions included implementing resident care based on physician orders and perform skin evaluations and skin treatments as required by skin treatment protocols Review of the job description for "Registered Nurse" dated , revealed the RN	N 054		

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N 054	Continued From page 7 would "provide direct nursing care to residents and supervise day-to-day nursing activities performed by nursing assistants in accordance with state and federal standards." Review of the "Facility Assessment" tool revised . . . . . revealed the facility would admit residents with skin integrity issues and provide skin and . . . care. Pattern Class III	N 054		
N 101 SS=E	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results.	N 101		

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N 101	Continued From page 8 This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the medical record accurately reflected Advanced Directives related to [redacted] ( ) over a four month period, for 1 of 1 resident reviewed for Advanced Directives of a total sample of 26 residents, (#12). Findings: Resident #12 was admitted to the facility on [redacted] with diagnoses including [redacted] and aneurysm. Review of the Minimum Data Set (MDS) significant change assessment with assessment reference date of [redacted] revealed resident #12 had a [redacted] score of 8 which indicated she had moderate [redacted] Review of resident #12's demographic information in the electronic medical record (EMR) identified her Advanced Directive as Full Code or full efforts. Review of the resident's paper chart on the nursing unit revealed a laminated green sheet that read, "Full Code." Review of the Medication Administration Record (MAR) dated [redacted] and [redacted] also identified resident #12's Advanced Directive as Full Code. Review of the "Order Summary Report" revealed active orders for Full Code dated [redacted]. An order dated [redacted] for Do Not Hospitalize even for acute issues, directed nurses to contact family	N 101	1.Resident # 12 □s status was immediately update in EMR, and yellow form was place in resident □s chart on [redacted] 2.Full house audit was completed immediately on [redacted] comparing EMR, Hard chart, Care plan and social service note on code status. 3.DON/designee to re-educate, license nursing staff, social services, and medical records on procedure for ensuring accurate Code status is present in EMR, hard chart and care plan. On admission, admitting nurse to review and verify code status with resident or responsible party to ensure accuracy. Code status orders to be obtained from MD and entered into EMR. Resident code status will again be reviewed and verified in clinical morning meeting by IDT team. Social Service director/designee to verify code status within 72 hours of admission. 4.Weekly audits to be completed by Social service/designee x 3 months then monthly. NHA/designee to present results of weekly audit at monthly QAPI for compliance or need for changes or extension beyond 3 months to POC if indicated.	

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N 101	Continued From page 9 for approval prior to any hospital transfer. Review of the "Social Services Notes" dated and read, "She is a . Reviewed and explained Resident Rights to resident." A note dated indicated resident #12's Advanced Directive status changed. It read, "She is a full code. Reviewed and explained Resident Rights to resident." A note dated read, "She is a . Reviewed and explained Resident Rights to resident." The Advanced Directives care plan initiated and revised identified resident #12's Advanced Directive as Full Code. The interventions included do not hospitalize, honor Advanced Directives and "In the event of and/or , honor resident's wishes." On at 4:32 PM, in a telephone interview, resident #12's daughter stated her mother did not want life saving measures in the event of or . She stated her mother's Advanced Directives had been given to the facility upon admission. On at 4:36 PM, the Social Services Director (SSD) stated she was responsible for reviewing and discussing residents' Advanced Directives with them or their representatives upon admission and regularly throughout their stay. The SSD stated she spoke to resident #12 and her family the day before and to her knowledge they did not want a . The SSD was informed of the telephone interview with resident #12's daughter who had just expressed her mother did not wish to be . The SSD placed a call to the resident's daughter who again	N 101		

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N 101	Continued From page 10 confirmed her mother did not want any life saving measures. The daughter informed the SSD the resident's Advanced Directives including a Living Will and a were provided upon admission three years ago. During review of the "Social Services Notes" with the SSD, she confirmed the discrepancies in her documentation regarding resident #12's code status. She said, "It is very disturbing not to have the correct code status documented." On at 4:55 PM, the Medical Records staff provided resident #12's overflow chart and explained these pages had been thinned from the paper chart over the years. During review of the overflow chart, the Medical Records staff discovered a yellow paper dated signed by resident #12 and her physician. The Medical Records staff stated resident #12 had been to the hospital several times and the was probably removed and not pulled forward on readmission. On at 5:05 PM, the Director of Nursing (DON) was informed that resident #12's medical record did not reflect the correct code status. The DON reviewed current and discontinued orders in the EMR and explained the full code order was entered off-site on during an EMR transition from one software provider to another. During review of the physician orders with DON, she confirmed resident #12 had an order for dated which was discontinued on and an order for Full Code was initiated on . The DON explained this discrepancy was missed during reconciliation. On at 10:41 AM, Registered Nurse (RN) B stated she was regularly assigned to care for	N 101		

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N 101	Continued From page 11 resident #12. RN B stated if she found the resident unresponsive and without vitals, she would pull up the EMR demographic sheet and check the medical chart to verify code status before initiating . . . . . ( ). RN B said, "If the code status was wrong, that would be a big mistake." On . . . . . at 11:13 AM, resident #12 emphasized she did not want to be . On at 11:28 AM, Licensed Practical Nurse (LPN) C/Nursing Supervisor stated should never be thinned from the medical chart. She confirmed she regularly cared for resident #12 and acknowledged if the resident's . . . stopped beating, she would have checked the chart and performed as there was a full code order. On . . . . . 2:51 PM, Medical Records staff confirmed she was responsible for thinning the medical charts. She stated an active should never be thinned from the chart. The facility's policy and procedure for "Residents' Rights Regarding Treatment and Advanced Directives" dated , read, "Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. . . .During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives." Pattern Class III	N 101		

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N 201	Continued From page 12	N 201		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care (l) The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure ,, was administered as ordered for 1 of 1 resident reviewed for , , care, (#12); failed to follow the Registered Dietitian's (RD) recommendations for fluid administration for 1 of 1 resident reviewed for , (#280); and failed to provide assistance with Activities of Daily Living (ADLs) related to , care for 1 of 1 resident reviewed for ADLs, (#11), of a total sample of 26 residents. Findings: 1. Resident #12 was admitted to the facility on with diagnoses including , , ( ), , , ( ), aneurysm and . Review of the Minimum Data Set (MDS) significant change assessment with assessment reference date of revealed resident #12 had a ( )	N 201	1. ,, was replaced and immediately placed in nares with resident permission. Nail care was immediately provided to resident # 11 on . CNA was immediately re-educated on providing nail care for residents and location of nail care supplies. Flush orders for resident #280 was immediately corrected in EMAR on to reflect 4 times a day. 2.Audit of current residents with ,, orders on were reviewed for placement and compliance with wearing ,, with no other discrepancies found. A nail audit was completed on on current residents. Nail care was provided for residents on. All residents with tub feeding orders were reviewed on for accuracy of transcription into EMAR. All discrepancies were addressed 3.DON/designee to re-educate nursing staff administering ,, as ordered, nursing staff on routine nail care for residents and location of nail care	

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N 201	Continued From page 13 score of 8 which indicated she had moderate [illegible]. She did not exhibit any behavioral symptoms and did not reject care that was necessary to achieve her goals for health and well-being. The document revealed the resident experienced [illegible] when lying flat and she received [illegible]. A care plan for "Potential for ineffective breathing related to diagnosis of [illegible] and [illegible]" was initiated on [illegible]. Interventions included, "Apply [illegible] per [physician] orders, Monitor for signs/symptoms of acute [illegible] insufficiency: [illegible], Restlessness, [illegible] at rest, [illegible], somnolence." Resident #12 had a care plan for behavior problems including removing [illegible] tubing was initiated [illegible] and revised on [illegible]. The care plan did not include any intervention or approaches to address the resident's removal of [illegible] tubing. Review of "Post [illegible] Screen Assessment" dated [illegible] revealed resident had a [illegible] on [illegible] with an intervention to check the resident every two hours to "ensure patient has [illegible] on." Review of resident #12's medical record revealed a physician order dated [illegible] for [illegible] at 5 liters per minute (L/min) continuously via [illegible]. An order dated [illegible] directed nurses to check the resident's [illegible] saturation level and assess, document and notify the physician if less than 90%. A normal [illegible] saturation level is 95% to 100%. Values under 90% are considered low and could cause [illegible], slow [illegible] rate and [illegible] (retrieved [illegible] from www.cdc.gov).	N 201	supplies, and accurately transcribing verbal orders into the EMAR/ETAR, and 24 hour chart check process. 4. Weekly audits will be conducted by DON/designee for compliance in [illegible] administration per physician order x3 months. Random weekly audits to be completed by DON/designee of residents' nails to ensure compliance with nail care x 3 months. Orders will be reviewed in clinical morning meeting for accuracy. Random audits of orders will be conducted weekly by the DON/designee for accuracy of transcription into EMAR/ETAR x 3 months. NHA/designee to present results of audits in monthly QAPI x 3 months for compliance or need for changes/extension beyond 3 months to POC if indicated.	

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	35961056	A. BUILDING: _____ B. WING _____	01/20/2022

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N 201	Continued From page 14 On [redacted] at 11:12 AM, resident #12 was in bed and wore a [redacted] connected to an [redacted] concentrator. The machine was set to deliver [redacted] at 5 L/min. On [redacted] at 11:18 AM, resident #12 was in bed, lying flat and did not have [redacted] in place. Resident stated she did not feel good. The [redacted] tubing was draped over the [redacted] concentrator approximately five [redacted] away from bed on the other side of the resident's nightstand. Resident #12 was slightly [redacted] and was not aware she did not have her [redacted] in place. She said, "The staff seem to think that if I don't have it on, I will pass out and die." On [redacted] at 11:20 AM, Licensed Practical Nurse (LPN) C/Nurse Supervisor was informed resident #12's [redacted] was not in place. LPN C validated the resident's [redacted] was not in place and confirmed it was draped over the concentrator and touched the floor. She confirmed resident #12 was bedbound and could not have placed the [redacted] that far away from the bed. On [redacted] at 11:25 AM, Certified Nursing Assistant (CNA) A stated she obtained resident #12's [redacted] saturation level earlier in that morning and obtained a reading of 90%. She could not recall if the reading was obtained with or without [redacted] in place. CNA A was asked to check the resident's [redacted] saturation level and discovered it was 88%. On [redacted] at 11:29 AM, LPN C stated when she last saw resident #12 at 9:30 AM, the [redacted] was in place. LPN C stated resident #12 required [redacted] due to a history of [redacted] failure. She explained the resident needed	N 201		

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N 201	Continued From page 15 continuous [illegible] at 5 L/min. She acknowledged the [illegible] should have been in place and worn continuously. On [illegible] at 10:41 AM, Registered Nurse (RN) B confirmed resident #12 was prescribed [illegible] at 5 L/min continuously but would sometimes take her [illegible] off and drop it on the floor next to the bed. RN B explained the resident needed [illegible] due to diagnoses of [illegible] and [illegible]. RN B stated without [illegible], the resident could become [illegible], disoriented and [illegible]. RN B stated an [illegible] saturation level of less than 90% was considered low and would be concerning. A review of "Progress Notes" from [illegible] through [illegible] revealed no nursing documentation regarding resident #12 removing her [illegible]. The facility's policy and procedure for "[illegible] Administration" dated [illegible] read, "[illegible] is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences." The document's guidelines indicated [illegible] was to be administered according to physician orders. 2. Resident #280 was admitted to the facility on [illegible] with diagnoses including difficulty swallowing, [illegible], status and protein calorie [illegible]. A [illegible] tube is a tube that is surgically inserted through the skin directly into the [illegible]. It is used to provide nourishment and water for people who cannot swallow correctly or	N 201		

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N 201	Continued From page 16 do not take enough food by . . . . to stay healthy (retrieved on from www.medlineplus.gov) Review of the MDS admission assessment with assessment reference date of . . . . . revealed resident #280 ha a score of 14 which indicated she had intact cognition. The document indicated resident #280 was diagnosed with . . . . . and had a . . . . . The assessment revealed that resident received 501 milliliters (ml) per day or more via . . . . . . Review of resident #280's medical record revealed a care plan for risk for fluid volume . . . . initiated on . . . . . The interventions included administer . . . . . and water flushes as ordered, and to monitor and report signs and symptoms of . A . . . . care plan dated . . . . . indicated resident #280 was dependent on . . . . . and water flushes. The care plan directed nurses to follow physician orders. Review of a "Medication Review Report" revealed a physician order dated . . . . . to administer 125 ml every six hours. Review of the Medication Administration Record (MAR) dated . . . . . revealed nursing documentation to validate resident #280 received 125 ml of water once every shift, three times daily, instead of every 6 hours, or four times daily, as ordered. Review of a "Nutrition Dietary" note dated . . . . revealed a recommendation by the RD to decrease resident #280's water flushes to 125 ml every six hours. On at 12:19 PM, resident #280 was	N 201		

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N 201	Continued From page 17 observed with very dry , . that stuck to her . . . as she talked. Resident #280 repeatedly picked at the peeling dried skin on her , . . On . . . . at 1:24 PM, the Consultant RD explained residents that needed required water flushes as . . . . . alone did not provide an adequate amount of fluid. She confirmed she reviewed resident #280's labs and made a recommendation for an appropriate amount of water flush to meet the resident's needs. The RD reviewed her progress notes and recommendations and validated resident #280 should receive 125 ml of water every six hours. She was prompted to review the MAR and acknowledged the documentation showed resident #280 received 375 ml of additional water daily instead of 500 ml required. The RD confirmed that receiving an inadequate amount of fluid could cause dry , . . On at 1:47 PM, LPN C/Nurse Supervisor confirmed the physician ordered 125 ml water flush for resident #280 every six hours. She reviewed the medical record and confirmed nurses had been administering water once every eight-hour shift rather than every six hours as ordered. LPN C stated she was regularly assigned to resident #280 and had administered the flush once per shift as she had not noticed the discrepancy. She stated that the resident could become without the proper amount of water administered. On . . . . at 3:31 PM, resident #280 stated she was still thirsty, and her , felt dry. On at 10:54 AM, RN B acknowledged she had administered the 125 ml water flush on her shift for resident #20 but did not notice the	N 201		

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N 201	Continued From page 18 order was entered incorrectly. The facility's policy and procedure for "Appropriate Use of " dated read, "It is a policy of this facility to ensure that a resident maintains acceptable parameters of nutritional and hydration status." Guidelines indicated residents who were dependent on would receive the appropriate treatment and services to prevent complications with including but not limited to 3. Resident #11 was admitted to the facility on with diagnoses including , generalized and limitation of activities due to . Review of the MDS Admission Assessment with assessment reference date of revealed resident #11 required limited assistance of one-person for personal hygiene. Section E0800 revealed resident #11 had not exhibited any behaviors for rejection of care. A "Self-Care " care plan was initiated on . Interventions included "Provide assistance to ADLs as indicated/documented. . . .Bathing/showering per facility protocol and [as needed]." These interventions were transcribed to the CNA Kardex or care plan. Review of nursing progress notes for revealed no documentation for resident #11 related to refusal of nail care. On at 10:46 AM, resident #11 was observed in bed. His were approximately 0.5 centimeters long. There was a	N 201		

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N 201	Continued From page 19 dark brown to black substance noted underneath all nails. Resident #11 was unable to recall when he last received nail care. On [redacted] at 10:50 AM, CNA A stated she was responsible for providing ADL care for her assigned residents. During observation of resident #11's [redacted] with CNA A, she acknowledged all [redacted] were long and dirty. CNA A stated she did not take care of residents' [redacted] as it was the nurse's responsibility. On [redacted] at 10:59 AM, RN B stated she was not aware she was supposed to do nail care. On [redacted] at 11:05 AM, during observation of resident #11's [redacted] with RN B, she confirmed his [redacted] were long and had dark brown to black substance underneath all nails. Resident #11's wife was at bedside, and stated she visited every day. She said, "I noticed his [redacted] were dirty." She stated she was told by a staff member that staff could not use nail clippers because the were too dangerous. Resident #11's wife retrieved an orange stick from her purse and explained she brought these items in herself. She stated she would never allow her husband's [redacted] to look like that if he were at home. On [redacted] at 11:09 AM, CNA A validated she did not attempt to clean resident #11's [redacted] after being made aware they were dirty the previous day. She did not offer an explanation regarding why she had not offered nail care. CNA A acknowledged she was responsible for providing all personal hygiene care for her assigned residents, and nail care was part of personal hygiene care.	N 201		

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N 201	Continued From page 20 On [redacted] at 11:22 AM, LPN C/Nursing Supervisor stated all nursing staff were responsible for [redacted] care. She confirmed CNA A should have provided resident #11's nail care when made aware the previous day. She explained [redacted] hygiene should be provided for all residents at a minimum before and after meals and on shower days. On [redacted] at 11:35 AM, the Director of Nursing (DON) stated CNAs were expected to do nail care during daily ADL care and at mealtimes. She stated nurses could also cut [redacted] or instruct CNAs to perform nail care as indicated. The DON acknowledged resident #11's nails should have been cut by CNA A when she was made aware of the issue the previous day. On [redacted] at 2:50 PM, the DON confirmed the CNA Kardex did not list nail care as a specific task because it was considered an expectation of basic personal hygiene care. Review of the job description for "Certified Nursing Assistant" dated [redacted], revealed the CNA would provide routine daily nursing care. The CNA's essential job functions included, "Assist patients/residents with Activities of Daily Living such as bathing, [redacted] grooming, eating, transferring, ambulating, toileting, and other resident needs." Review of the job description for "Registered Nurse" dated [redacted], revealed the RN would "provide direct nursing care to residents and supervise day-to-day nursing activities performed by nursing assistants. . . ." The facility's policy and procedure for "Nail Care" dated [redacted] read, "The purpose of this	N 201		

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N 201	Continued From page 21 procedure is to provide guidelines for the provisions of care to a resident's nails for good grooming and health." The guidelines included. . . ."3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis; 4. Routine nail care, to include trimming and filing, will be provided as needed; and 6. Procedure: . . . .c. Gently clean underneath nails with "orange stick." Review of the "Facility Assessment" tool revised on revealed the facility would provide required assistance with ADL care. Class III	N 201		
CZ815	408.809(1)( ); 435.02(2); 435.06 FS Background Screening; Prohibited Offenses 408.809 Background screening; prohibited offenses.- (1) Level 2 background screening pursuant to chapter 435 must be conducted through the agency on each of the following persons, who are considered employees for the purposes of conducting screening under chapter 435: (a) The licensee, if an individual. (b) The administrator or a similarly titled person who is responsible for the day-to-day operation of the provider. (c) The financial officer or similarly titled individual who is responsible for the financial operation of the licensee or provider. (d) Any person who is a controlling interest. (e) Any person, as required by authorizing statutes, seeking employment with a licensee or provider who is expected to, or whose	CZ815		

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CZ815	Continued From page 22	CZ815		

responsibilities may require him or her to, provide personal care or services directly to clients or have access to client funds, personal property, or living areas; and any person, as required by authorizing statutes, [illegible] with a licensee or provider whose responsibilities require him or her to provide personal care or personal services directly to clients, or [illegible] with a licensee or provider to work 20 hours a week or more who will have access to client funds, personal property, or living areas. Evidence of contractor screening may be retained by the contractor's employer or the licensee.

(3) All [illegible] must be provided in electronic format. Screening results shall be reviewed by the agency with respect to the offenses specified in s. 435.04 and this section, and the qualifying or disqualifying status of the person named in the request shall be maintained in a database. The qualifying or disqualifying status of the person named in the request shall be posted on a secure website for retrieval by the licensee or designated agent on the licensee's behalf.

(4) In addition to the offenses listed in s. 435.04, all persons required to undergo background screening pursuant to this part or authorizing statutes must not have an [illegible] awaiting final disposition for, must not have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, and must not have been adjudicated delinquent and the record not have been sealed or expunged for any of the following offenses or any similar offense of another jurisdiction:
(a) Any authorizing statutes, if the offense was a felony.
(b) This chapter, if the offense was a felony.

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CZ815	Continued From page 23 (c) Section 409.920, relating to Medicaid provider fraud. (d) Section 409.9201, relating to Medicaid fraud. (e) Section 741.28, relating to domestic violence. (f) Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this subsection. (g) Section 784.03, relating to battery, if the victim is a . . . . . adult as defined in s. 415.102 or a patient or resident of a facility licensed under chapter 395, chapter 400, or chapter 429. (h) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems. (i) Section 817.234, relating to false and fraudulent insurance claims. (j) Section 817.481, relating to obtaining goods by using a false or expired credit card or other credit device, if the offense was a felony. (k) Section 817.50, relating to fraudulently obtaining goods or services from a health care provider. (l) Section 817.505, relating to patient brokering. (m) Section 817.568, relating to criminal use of personal identification information. (n) Section 817.60, relating to obtaining a credit card through fraudulent means. (o) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony. (p) Section 831.01, relating to forgery. (q) Section 831.02, relating to uttering forged instruments. (r) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes. (s) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes. (t) Section 831.30, relating to fraud in obtaining medicinal drugs. (u) Section 831.31, relating to the sale,	CZ815		

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CZ815	Continued From page 24 manufacture, delivery, or possession with the intent to sell, manufacture, or deliver any counterfeit controlled substance, if the offense was a felony. (v) Section 895.03, relating to racketeering and collection of unlawful debts. (w) Section 896.101, relating to the Florida Money Laundering Act. If, upon rescreening, a person who is currently employed or with a licensee and was screened and qualified under s. 435.04 has a disqualifying offense that was not a disqualifying offense at the time of the last screening, but is a current disqualifying offense and was committed before the last screening, he or she may apply for an exemption from the appropriate licensing agency and, if agreed to by the employer, may continue to perform his or her duties until the licensing agency renders a decision on the application for exemption if the person is eligible to apply for an exemption and the exemption request is received by the agency no later than 30 days after receipt of the rescreening results by the person. (5) The costs associated with obtaining the required screening must be borne by the licensee or the person subject to screening. Licensees may reimburse persons for these costs. The Department of Law Enforcement shall charge the agency for screening pursuant to s. 943.053(3). The agency shall establish a schedule of fees to cover the costs of screening. (6)(a) As provided in chapter 435, the agency may grant an exemption from disqualification to a person who is subject to this section and who: 1. Does not have an active professional license or certification from the Department of Health; or	CZ815		

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CZ815	Continued From page 25 2. Has an active professional license or certification from the Department of Health but is not providing a service within the scope of that license or certification. (b) As provided in chapter 435, the appropriate regulatory board within the Department of Health, or the department itself if there is no board, may grant an exemption from disqualification to a person who is subject to this section and who has received a professional license or certification from the Department of Health or a regulatory board within that department and that person is providing a service within the scope of his or her licensed or certified practice. (7) The agency and the Department of Health may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this section, chapter 435, and authorizing statutes requiring background screening and to implement and adopt criteria relating to retaining [illegible] pursuant to s. 943.05(2). (8) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages arising against, an employer that, upon notice of a disqualifying offense listed under chapter 435 or this section, terminates the person against whom the report was issued, whether or not that person has filed for an exemption with the Department of Health or the agency. 435.06 Exclusion from employment.- (1) If an employer or agency has reasonable cause to believe that grounds exist for the denial or termination of employment of any employee as a result of background screening, it shall notify the employee in writing, stating the specific	CZ815		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
CZ815	Continued From page 26 record that indicates noncompliance with the standards in this chapter. It is the responsibility of the affected employee to contest his or her disqualification or to request exemption from disqualification. The only basis for contesting the disqualification is proof of mistaken identity. (2)(a) An employer may not hire, select, or otherwise allow an employee to have contact with any person that would place the employee in a role that requires background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any person that would place the employee in a role that requires background screening unless the employee is granted an exemption for the disqualification by the agency as provided under s. 435.07. (b) If an employer becomes aware that an employee has been for a disqualifying offense, the employer must remove the employee from contact with any person that places the employee in a role that requires background screening until the is resolved in a way that the employer determines that the employee is still eligible for employment under this chapter. (c) The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of this chapter or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07. (d) An employer may hire an employee to a	CZ815		

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	35961056	A. BUILDING: _____ B. WING _____	01/20/2022

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CZ815	Continued From page 27 position that requires background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. (3) Any employee who refuses to cooperate in such screening or refuses to timely submit the information necessary to complete the screening, including if required, must be disqualified for employment in such position or, if employed, must be dismissed. (4) There is no reemployment assistance or other monetary liability on the part of, and no cause of action for damages against, an employer that, upon notice of a conviction or for a disqualifying offense listed under this chapter, terminates the person against whom the report was issued or who was , regardless of whether or not that person has filed for an exemption pursuant to this chapter. 435.02 Definitions.-For the purposes of this chapter, the term: (2) "Employee" means any person required by law to be screened pursuant to this chapter, including, but not limited to, persons who are contractors, licensees, or volunteers. This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to have a Level 2 criminal background screening conducted every five years as required for 1 of 10 employee files reviewed, (, , Assistant K).	CZ815	1)Employee K level 2 background screening cleared on . All employees were audited for level 2 background screening on , all discrepancies were addressed. 2)NHA/ designee re-educated Human	

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CZ815	Continued From page 28 Findings: On [redacted] at 2:39 PM, review of the personnel file for staff K with Human Resources Director (HR) revealed she was hired on [redacted]. Her most recent Level 2 criminal background screening report revealed the background check was completed on [redacted] and had an eligible status at that time. Review of staff K's background screening in the Clearinghouse House Roster revealed comment under "AHCA Provider//Facility Licensure," that a "New Screening is Required." The HR Director indicated [redacted] were due every 5 years. She stated the last ones were done on [redacted] and staff K was due for [redacted] on [redacted]. She stated we should have checked monthly to make sure employees were current with background screening status. She said, "I think this one was missed," and added that she was responsible for checking. Review of the facility Human Resources Director Job Description showed "Essential Job Functions: 1. The major areas directed are: .... e. employment and compliance to regulatory concerns;" Review facility Background screening Policy revealed "STANDARD In order to protect our residents, team members and the organization's assets, it is our standard to conduct a pre-employment Background Screening of all potential team members to ensure that all team members meet state and/or company requirements." Under Procedure the policy showed "Background Screening: Must meet AHCA's Standards Level 2 Background Screening-All applicants must pass a Level 2	CZ815	Resources on level 2 screening process for new and current employees on [redacted]. 3)Human Resources to conduct weekly audits on employee level 2 background screenings x 3 months, then monthly. 4)NHA/designee to present results of weekly audits in monthly QAPI x 3 months for compliance or need for changes/extension 3 months to POC if indicated.	

Agency for Health Care Administration

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CZ815	Continued From page 29 Background Screening prior to commence working."	CZ815		

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F 000	INITIAL COMMENTS A recertification survey was conducted from to . Westminster Baldwin Park was not in compliance with 42 CFR Part 483 and 488, Requirements for Long Term Care Facilities.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. ( ) If an adult individual is , at the time of admission and is unable to receive information or whether or not he or she has executed an advance directive, the facility	F 578		

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

Electronically Signed /2022

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

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F 578	Continued From page 1 may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the medical record accurately reflected Advanced Directives related to ( ) over a four month period, for 1 of 1 resident reviewed for Advanced Directives of a total sample of 26 residents, (#12). Findings: Resident #12 was admitted to the facility on with diagnoses including , and aneurysm. Review of the Minimum Data Set (MDS) significant change assessment with assessment reference date of revealed resident #12 had a score of 8 which indicated she had moderate . Review of resident #12's demographic information in the electronic medical record (EMR) identified her Advanced Directive as Full Code or full efforts. Review of the resident's paper chart on the nursing unit revealed a laminated green sheet	F 578	1)Resident # 12's status was immediately update in EMR, and yellow form was place in resident's chart on . 2)Full house audit was completed immediately on comparing EMR, Hard chart, Care plan and social service note on code status. No discrepancies were noted. 3)DON/designee to re-educate, license nursing staff, social services, and medical records on procedure for ensuring accurate Code status is present in EMR, hard chart and care plan. On admission, admitting nurse to review and verify code status with resident or responsible party to ensure accuracy. Code status orders to be obtained from MD and entered into EMR. Resident code status will again be reviewed and verified in clinical morning meeting by IDT team. Social Service director/designee to verify code status within 72 hours of admission. 4)Weekly audits to be completed by Social service/designee x3 months then	

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F 578	Continued From page 2 that read, "Full Code." Review of the Medication Administration Record (MAR) dated and also identified resident #12's Advanced Directive as Full Code. Review of the "Order Summary Report" revealed active orders for Full Code dated . An order dated for Do Not Hospitalize even for acute issues, directed nurses to contact family for approval prior to any hospital transfer. Review of the "Social Services Notes" dated and read, "She is a . Reviewed and explained Resident Rights to resident." A note dated indicated resident #12's Advanced Directive status changed. It read, "She is a full code. Reviewed and explained Resident Rights to resident." A note dated read, "She is a . Reviewed and explained Resident Rights to resident." The Advanced Directives care plan initiated and revised identified resident #12's Advanced Directive as Full Code. The interventions included do not hospitalize, honor Advanced Directives and "In the event of and/or , , , honor resident's wishes." On at 4:32 PM, in a telephone interview, resident #12's daughter stated her mother did not want life saving measures in the event of or , , . She stated her mother's Advanced Directives had been given to the facility upon admission.	F 578	monthly. NHA/designee to present results of weekly audit at monthly QAPI for compliance or need for changes or extension beyond 3 months to POC if indicated.	

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F 578	Continued From page 3	F 578		

On [redacted] at 4:36 PM, the Social Services Director (SSD) stated she was responsible for reviewing and discussing residents' Advanced Directives with them or their representatives upon admission and regularly throughout their stay. The SSD stated she spoke to resident #12 and her family the day before and to her knowledge they did not want a [redacted]. The SSD was informed of the telephone interview with resident #12's daughter who had just expressed her mother did not wish to be [redacted]. The SSD placed a call to the resident's daughter who again confirmed her mother did not want any life saving measures. The daughter informed the SSD the resident's Advanced Directives including a Living Will and a [redacted] were provided upon admission three years ago.

During review of the "Social Services Notes" with the SSD, she confirmed the discrepancies in her documentation regarding resident #12's code status. She said, "It is very disturbing not to have the correct code status documented."

On [redacted] at 4:55 PM, the Medical Records staff provided resident #12's overflow chart and explained these pages had been thinned from the paper chart over the years. During review of the overflow chart, the Medical Records staff discovered a yellow paper [redacted] dated signed by resident #12 and her physician. The Medical Records staff stated resident #12 had been to the hospital several times and the [redacted] was probably removed and not pulled forward on readmission.

On [redacted] at 5:05 PM, the Director of Nursing (DON) was informed that resident #12's medical record did not reflect the correct code status. The

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F 578	Continued From page 4	F 578		

DON reviewed current and discontinued orders in the EMR and explained the full code order was entered off-site on . . . . during an EMR transition from one software provider to another. During review of the physician orders with DON, she confirmed resident #12 had an order for . . dated . . . . . which was discontinued on and an order for Full Code was initiated on . . . . . . The DON explained this discrepancy was missed during reconciliation.

On at 10:41 AM, Registered Nurse (RN) B stated she was regularly assigned to care for resident #12. RN B stated if she found the resident unresponsive and without vitals, she would pull up the EMR demographic sheet and check the medical chart to verify code status before initiating , ( ). RN B said, "If the code status was wrong, that would be a big mistake."

On at 11:13 AM, resident #12 emphasized she did not want to be . . . . . .

On . . . . . at 11:28 AM, Licensed Practical Nurse (LPN) C/Nursing Supervisor stated . . should never be thinned from the medical chart. She confirmed she regularly cared for resident #12 and acknowledged if the resident's stopped beating, she would have checked the chart and performed . as there was a full code order.

On 2:51 PM, Medical Records staff confirmed she was responsible for thinning the medical charts. She stated an active should never be thinned from the chart.

The facility's policy and procedure for "Residents'

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F 578	Continued From page 5 Rights Regarding Treatment and Advanced Directives" dated , read, "Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. . . .During the care planning process, the facility will identify, clarify, and review with the resident or legal representative whether they desire to make any changes related to any advance directives."	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-( )(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or , , ... status (that is, a deterioration in health, mental, or , , status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		

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F 580	Continued From page 6 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. ( ) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to notify the physician and resident representative of signs and symptoms of a skin for 1 of 1 resident reviewed for notification of change of condition out of a total sample of 26 residents, (#12). Findings: Resident #12 was admitted to the facility on with diagnoses including prurigo nodularis, a skin condition associated with and severe itching (retrieved from www.nih.gov) Review of the Minimum Data Set (MDS)	F 580	1)ARNP was immediately notified of assessment of resident #12 is left lower extremity on , orders obtained and entered into EMR. LPN immediately educated on Change in Condition, MD notification, obtaining orders and appropriate documentation. 2)Full house audit of resident conditions completed on with notification of changes reported to MD, orders obtained and documentation completed if indicated. 3)DON/designee to re-educate nursing staff on Change in Condition, MD	

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F 580	Continued From page 7 significant change in status assessment with assessment reference date of revealed resident #12 had a score of 8 which indicated she had moderate . The document indicated the resident had no or but had . A care plan for altered skin integrity was initiated on and revised . Interventions included to monitor for and document location, size and treatment of skin injury and to report abnormalities to physician. Review of resident #12's electronic medical record demographic information revealed the resident's daughter was listed as the authorized "Emergency Contact #1" and as her power of attorney for care. On at 11:15 AM, resident #12 stated she had , in her left and had a low-grade for the last couple of days. On at 11:29 AM, Licensed Practical Nurse (LPN) C/Nurse Supervisor stated resident #12 had a in . She stated the resident had been seen by a care in the past for a . She described the area as still being red. On at 11:46 AM, during observation of resident #12's left lower with LPN C, she confirmed there was an area of redness and that was warm to the touch. There were two scabbed areas above the resident's ankle that were each approximately one centimeter in diameter. The area of redness around the scabbed areas was ten centimeters	F 580	notification, obtaining orders and appropriate documentation. Change in condition will be reviewed and verified in clinical morning meeting by IDT team. 4)Weekly audits of resident condition to be completed for 3 months by DON/designee for compliance in Change in Condition, MD notification, obtaining orders and appropriate documentation. NHA/designee to present results of weekly audits in monthly QAPI x 3 months for compliance or need for changes or extension beyond 3 months to POC if indicated.	

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F 580	Continued From page 8 wide and covered the circumference of her lower . There was no in place. On at 12:01 PM, LPN C stated she was assigned to care for resident #12 on Monday, . She confirmed the resident's left lower had been red and on that day. LPN C acknowledged the change in the resident's condition of her was significant and should have been reported to the physician. She acknowledged she had not completed any change in condition documentation nor notified the physician and the family. On at 12:15 PM, the facility's Registered Nurse Consultant (RNC) and LPN C spoke with the Advanced Practice Registered Nurse (APRN) and informed her of the area on resident #12's left lower that was and warm to the touch. The APRN gave an order for 100 milligrams (mg) twice a day for seven days to treat signs and symptoms of . On at 12:22 PM, the Director of Nursing assessed resident #12's left lower and validated the presence of redness and . She confirmed the condition of the resident's should have been identified by all staff assigned to the resident and reported as a change in condition. On at 11:19 AM, Certified Nursing Assistant (CNA) A confirmed she saw the red area on resident #12 left lower on Tuesday, . She stated the area had been red for a while and had been reported to the nurse. Review of the progress notes for the entire month of did not reveal any	F 580		

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F 580	Continued From page 9 documentation regarding signs and symptoms of to resident #12's left lower and no documentation of reporting of a change in condition. Review of the job description for "Licensed Practical Nurse" dated , revealed the LPN's essential job functions included evaluation of resident needs, notification of changes to physician and obtaining appropriate orders. The facility's policy and procedure for "Notification of Changes" dated read, "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification." The guidelines indicated circumstances which required notification and included change in resident's physical condition and a need to implement a new treatment.	F 580		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		

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F 655	Continued From page 10 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) , , services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. ( ) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure baseline care plan summaries were reviewed with resident or resident representative for 7 of 30 newly admitted residents out of a total sample of 26 residents, (#127, #125, #126, #128, #2, #19, and #174). Findings:	F 655	1)Baseline Care Plans and current medication lists were printed for residents # 2, 19, 125, 126, 127,128 and 174. 2)Baseline care plans and medication lists were reviewed with resident or resident representative with signatures being obtained or verbal signature via telephone	

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F 655

Continued From page 11

1. Resident #127 was admitted to the facility on ...... with diagnoses of difficulty walking, ..., ..., ..., ... left ...... and ...... disc displacement.

A review of the medical record revealed a Clinical Admission Evaluation was signed and dated on ...... by the Assistant Director of Nursing (ADON 100 hall). A Baseline Care Plan could not be found in the electronic or paper medical record. On ...... at 3:16 PM, the Medical Records Director stated the new residents did not have a baseline care plan but they had an assessment. She stated they did not do baseline care plans, only comprehensive care plans were done. She said, "Yes, aware the residents are supposed to have a baseline care plan and nursing is supposed to do the baseline care plans."

Further review of the resident's paper chart and electronic medical record with the Director of Nursing (DON) revealed the Summary of Signatures for the Baseline Care Plan Assessment form dated ...... and ...... were signed by ADON 100 hall, the ...... Manager and Social Services Director (SSD). The section for resident or representative signature and date were blank.

On ...... at 6:13 PM, resident #127 was observed laying in bed watching TV. She stated the facility had not reviewed a baseline care plan or review any of her medications with her.

2. Resident #125 was admitted to the facility on ...... with diagnoses of ...... of ......, and

F 655 (Provider's Plan of Correction)

with 2 nurse witness on .... Baseline care plans were audited for documentation of care plan being reviewed with resident or representative as applicable. Baseline care plans without documentation were printed along with current medication list. ADON/designee reviewed with resident or resident representative as applicable care plan obtaining signatures or verbal signature via telephone with 2 nurse witness.

3)DON/designee to re-educate nursing staff and IDT on new Baseline care plan process on .... Baseline careplan will be reviewed and verified in clinical morning meeting by IDT team.

4)Weekly audits to be completed by DON/designee for 3 months to ensure Baseline care plan is completed and reviewed with resident/resident responsible party within 48 hours. NHA/designee to present results of weekly audits in monthly QAPI meeting x 3 months for compliance or need for changes or extension beyond 3 months to POC if indicated

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F 655	Continued From page 12 right acetabulum, [illegible] of [illegible], and [illegible]. Review of the electronic medical record revealed Clinical Admission Evaluation signed and dated on [illegible] by Registered Nurse (RN) L. The evaluation identified concerns with [illegible] status, [illegible] requiring assistance with [illegible], walker needed for unsteady gait and noted resident #125 participated in physical, occupational and [illegible]. The Baseline Care Plan dated [illegible] and [illegible] revealed signatures by ADON 200 hall, SSD and [illegible], Manger. The signature for resident/representative was missing indicating the resident and representative were not provided a review or copy of the baseline care plan. 3. Resident #126 was admitted to the facility on [illegible] with diagnoses of oral [illegible], [illegible], [illegible], and [illegible]. The medical record reflected the Clinical Admission Evaluation was completed on and signed by RN M. The evaluation indicated left and right [illegible], modified diet consistency, poor balance, and a manual wheelchair to be used for assistive device. On [illegible] at 3:16 PM, the DON stated that baseline care plans were completed within 48 hours of admission and reviewed with the resident or their representative. On [illegible] at 6:15 PM, resident #126 said, "I did not sign anything." He stated the facility did not discuss anything with him, they "just put me in the	F 655		

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F 655	Continued From page 13 room." Review of the medical record revealed no signatures or date from resident or representative attesting to reviewing summary of the Baseline Care Plan or medications. 4. Resident #128 was admitted to the facility on [redacted] with diagnoses of [redacted], right [redacted] right [redacted], and [redacted]. Review of the record showed Clinical Admission Evaluation dated [redacted] completed and signed by ADON 200 hall. The assessment reflected assistance needed with [redacted], assistive device of a grab bar, low bed manual wheelchair, walker and upper extremity [redacted] on one side. Further review of the medical record revealed a baseline care plan dated and signed by ADON 200 hall on [redacted] and by the [redacted] Manager and SSD on [redacted]. The section noting the baseline care plan was reviewed with the resident and or resident representative was blank. On [redacted] at 3:45 PM, the DON stated nursing staff were responsible for initiating the baseline care plan on admission and then other departments would complete their section of the care plan. She said the manager would then review the care plan, print it along with the medication list and review it with the resident and/or representative. After the review, the resident/representative would sign it. On [redacted] at 6:08 PM, resident #128 stated she did not discuss or sign any care plan. She said	F 655		

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F 655	Continued From page 14	F 655		

there was no discussion of her plan of care or medications. She added that she would have liked a list of her medications and discuss her plan of care with the staff.

5. Resident #2 was admitted to the facility on [redacted] with diagnoses of surgery [redacted] system, difficulty walking, [redacted], atherosclerotic [redacted], [redacted], and severe protein-calorie [redacted], [redacted], and [redacted].

A review of the medical record revealed Clinical Admission Evaluation signed and dated on [redacted] by RN N. The medical record did not reveal any signed or dated review of the baseline care plan summary with the resident/representative.

On [redacted] at 3:16 PM, the DON stated the facility had a check system in the electronic record. She stated when the baseline care plan summary was reviewed and signed by the resident/representative, it was locked in the electronic system. She explained it was her responsibility to ensure baseline care plans were completed and reviewed with the resident/representative within the required timeframe.

Review of the medical record paper chart and electronic chart with the DON revealed the signature from resident #2 was blank which indicated the plan had not been reviewed with the resident/representative.

6. Resident #19 was admitted to the facility on [redacted]. Review of the resident's medical record revealed Baseline Care Plan was completed on [redacted]. There was no documented evidence

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F 655	Continued From page 15 the resident and/or her representative were provided a review or copy of the Baseline Care Plan. On [redacted] at approxiamtely 3:45 PM, the DON reviewed the resident's medical record and acknowledged there was no evidence that either the resident or her representative were provided a summary of the Baseline Care Plan. 7. Resident #174 was admitted to the facility on [redacted] and the resident's Baseline Care Plan was completed on [redacted]. A review of the resident's medical record did not show any evidence the resident and/or his representative received a summary of the Baseline Care Plan. On at 3:45 PM, the DON could not provide any evidence the Baseline Care Plan summary was given to the resident or his representative. Review of the facility's Baseline Care Plan Policy showed under "Policy Explanation and Compliance Guidelines: ....#3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. #4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand..."	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and [redacted]	F 656		

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F 656	Continued From page 16 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and , , well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. ( )In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician orders for treatment as directed in the comprehensive care plan for 1 of 1 resident reviewed for non-pressure skin conditions out of	F 656	1)Treatment orders were reviewed for resident #12 and new orders obtained from ARNP on . 2)Full house skin check was completed	

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F 656	Continued From page 17 a total sample of 26 residents, (#12). Findings: Resident #12 was admitted to the facility on with diagnoses including prurigo nodularis, a skin condition associated with and severe itching (retrieved from www.nih.gov). Review of the Minimum Data Set significant change in status assessment with assessment reference date of revealed resident #12 had a score of 8 which indicated she had moderate . The document revealed the resident did not exhibit any behavioral symptoms including rejection of care. The assessment indicated resident #12 had skin conditions including which required . A care plan for at risk for altered skin integrity was initiated on . Interventions included follow facility protocols for treatment of injury; monitor for and document location, size and treatment of skin injury, and report abnormalities to physician. The care plan directed nurses to perform care and apply treatments to the residents left anterior as ordered. Review of resident #12's medical record revealed a physician order dated to cleanse the left anterior with normal dry and apply Medi-honey and foam daily and as needed. Review of the Treatment Administration Record (TAR) for revealed nursing documentation to validate resident #12's	F 656	on on current residents. Treatment orders were reconciled with results of full house skin check along with a visual check to ensure ordered treatment was in place. No other discrepancies were noted. 3)DON/designee to re-educate licensed nurses on completing treatment orders as ordered by physician. Weekly audits to be completed by DON/designee x 3 months on compliance with treatment orders being completed as ordered 4)NHA/designee to present results of weekly audits in monthly QAPI x 3 months for compliance or need for changes or extension beyond 3 months to POC if indicated.	

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F 656	Continued From page 18 treatment was applied as ordered. Review of a " Evaluation & Management Summary" dated revealed resident #12's left anterior was resolved on . However, review of "Weekly Skin Inspection" forms dated and indicated resident's skin was not intact but the areas noted were not new. A form dated revealed resident #12's skin was intact. On at 11:46 AM, during observation of resident #12's left lower with Licensed Practical Nurse (LPN) C, she confirmed there was an area of redness and that was warm to the touch. There were two scabbed areas above the resident's ankle that were each approximately one centimeter in diameter. The area of redness around the scabbed areas was ten centimeters wide and covered the circumference of her lower . There was no in place. On at 12:01 PM, LPN C stated she was assigned to care for resident #12 on Monday, . She confirmed the resident's left lower had been red and on that day. LPN C acknowledged the change in the resident's condition of her was significant and should have been reported to the physician. She acknowledged she had not completed any change in condition documentation nor notified the physician and the family. On at 12:22 PM, the Director of Nursing assessed resident #12's left lower and validated the presence of redness and . She confirmed the condition of the resident's should have been identified by all	F 656		

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F 656	Continued From page 19	F 656		

staff assigned to the resident and reported to the physician. There was no ﹏ in place.

On at 11:13 AM, resident #12's left lower ﹏ remained red and . There was no ﹏ noted as directed by the plan of care.

On at 4:25 PM, resident #12's assigned nurse, Registered Nurse (RN) D stated he was aware of a on the resident's left lower ﹏. He stated he applied ordered treatment to the area during the evening shift. Review of the TAR with RN D revealed a physician order scheduled for 4:00 PM daily and as needed. Observation of resident #12's ﹏ with RN D revealed there was still no ﹏ in place. Resident #12 stated nurses applied ﹏. sometimes. She said, "If they put a small one on, it off by itself. If they put a large one, sometimes it stays."

On at 4:33 PM, the DON was informed there was a treatment order for resident #12. She expressed surprise and stated she was not aware of any active treatment orders. She stated during a discussion with the Advanced Practice Registered Nurse (APRN) yesterday, she stated she no longer wanted a ﹏ applied to the area. The DON was informed during observation on and resident #12 did not have a ﹏ in place. The DON confirmed the new order to discontinue the treatment was never transcribed to the medical record.

On at 5:02 PM, the DON stated she contacted RN B who documented application of ﹏ for resident #12 on 4 days the

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F 656	Continued From page 20 previous week. She said RN B informed her she did not recall doing a [illegible]. Review of the job description for "Licensed Practical Nurse" dated [illegible], revealed the LPN's essential job functions included implementing resident care based on physician orders and perform skin evaluations and skin treatments as required by skin treatment protocols Review of the job description for "Registered Nurse" dated [illegible], revealed the RN would "provide direct nursing care to residents and supervise day-to-day nursing activities performed by nursing assistants in accordance with state and federal standards." Review of the "Facility Assessment" tool revised [illegible] revealed the facility would admit residents with skin integrity issues and provide skin and [illegible] care.	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-( ) §483.21(c)(2) Discharge Summary When the facility [illegible] discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or [illegible], and pertinent lab, [illegible], and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's	F 661		

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F 661	Continued From page 21 representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). ( ) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide a discharge summary which included a recapitulation of the resident's stay including diagnoses, course of illness/treatment, , , and pertinent lab, , and consultation results for 1 of 1 sampled resident of a total sample of 26 residents, (#18). Findings: Resident #18 was admitted on with diagnoses including of , , oral phase, acquired absence of left below , acquired absence of right above , type 2 with , and atherosclerotic . The residents' Admission Minimum Data Set (MDS) dated indicated he had moderate , and planned to be discharged to his home.	F 661	1)Recapitulation of Stay for resident # 18 completed on . 2)Implementation of Recapitulation of Stay form included in facility EMR system on . 3)DON/designee to in-service facility staff on new Recapitulation of Stay and requirements for completion, and compliance in completing Recapitulation of Stay. Weekly audits of discharged residents to home will be completed by DON/designee for one month, then random audits monthly for 2 months. NHA/designee to present results of audits in monthly QAPI x 3 months for compliance or need for changes or extension beyond 3 months to POC if indicated.	

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F 661	Continued From page 22	F 661		

The Social Service Director (SSD) initial assessment dated reflected resident #18's length of stay would be four weeks, then return home with home health care services.

A review of resident #18's discharge care plan revealed the resident wished to return home upon discharge. The goal included communicating required assistance post-discharge and the services required to meet needs before discharge.

Resident #18's physician orders reflected skilled ( ) to evaluate and treat 5 times per week for four weeks for self-care training, therapeutic activities, and therapeutic exercise. ( ) 5 times per week for 4 weeks, with treatment to include therapeutic exercises, re-education, therapeutic activities, patient/caregiver education, and discharge planning. (ST) to evaluate and treat as indicated 5 times per week for 4 weeks for for diet trials/modifications, compensatory strategy training. The physician orders noted resident to discharge home on with Home health and .

Review of resident #18's medical record revealed the discharge summary did not include a recapitulation of the resident's stay that included diagnoses, course of illness/treatment or and pertinent lab, and consultation results.

On at 2:26 PM, the Director of Nursing (DON) acknowledged a recapitulation of stay was

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F 661	Continued From page 23 not done. The DON noted that recapitulation of stay should have included a summary of the resident's care and ensured appropriate care after discharge. A review of the facility's policy and procedure for "Discharge Summary and Plan of care" revealed, 3) "Upon discharge of a resident (other than in emergency to hospital or . . . .), a Discharge Summary will be provided to the receiving care provider. The Discharge Summary should include a. An overview of the resident's stay that includes but is not limited to: diagnoses, course of illness/treatment or , , , and pertinent lab, ... , and consultation results."	F 661		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide assistance with Activities of Daily Living (ADLs) related to . . . . care for 1 of 1 resident reviewed for ADLs, of a total sample of 26 residents, (#11). Findings: Resident #11 was admitted to the facility on . . . . . with diagnoses including . . . . , generalized . . . . . and limitation of activities due to . .	F 677	1)Nail care was immediately provided to resident # 11 on . . CNA was immediately re-educated on providing nail care for residents and location of nail care supplies. 2)A nail audit was completed on . . . . . on current residents. Nail care was provided for residents. 3)DON/designee to re-educate nursing staff on routine nail care for residents and location of nail care supplies.	

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F 677	Continued From page 24 Review of the Minimum Data Set (MDS) Admission Assessment with assessment reference date of . . . revealed resident #11 required limited assistance of one-person for personal hygiene. Section E0800 revealed resident #11 had not exhibited any behaviors for rejection of care. A "Self-Care . . . " care plan was initiated on . Interventions included "Provide assistance to ADLs as indicated/documented. . . .Bathing/showering per facility protocol and [as needed]." These interventions were transcribed to the Certified Nursing Assistant (CNA) Kardex or care plan. Review of nursing progress notes for revealed no documentation for resident #11 related to refusal of nail care. On . . . . . at 10:46 AM, resident #11 was observed in bed. His were approximately 0.5 centimeters long. There was dark brown to black substance noted underneath all nails. Resident #11 was unable to recall when he last received nail care. On at 10:50 AM, CNA A stated she was responsible for providing ADL care for her assigned residents. During observation of resident #11's with CNA A, she acknowledged all were long and dirty. CNA A stated she did not take care of residents' as it was the nurse's responsibility. On at 10:59 AM, Registered Nurse (RN) B stated she was not aware she was supposed to do nail care.	F 677	4)Random weekly audits to be completed by DON/designee of residents nails to ensure compliance with nail care x 3 months. NHA/designee to present results of weekly audits in monthly QAPI x 3 months for compliance or need for changes or extension beyond 3 months to POC if indicated.	

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F 677	Continued From page 25 On [redacted] at 11:05 AM, during observation of resident #11's [redacted] with RN B, she confirmed his [redacted] were long and had dark brown/black substance underneath all nails. Resident #11's wife was at the bedside, and stated she visited every day. She said, "I noticed his [redacted] were dirty." She explained she was told by a staff member that staff could not use nail clippers because they were too dangerous. Resident #11's wife retrieved an orange stick from her purse and explained she brought these items in herself. She said she would never allow her husband's [redacted] to look like that if he were at home. On [redacted] at 11:09 AM, CNA A validated she did not attempt to clean resident #11's [redacted] after being made aware they were dirty the previous day. She did not offer an explanation why she had not offered nail care. CNA A acknowledged she was responsible for providing all personal hygiene care for her assigned residents, and nail care was part of personal hygiene care. On [redacted] at 11:22 AM, Licensed Practical Nurse (LPN) C/Nursing Supervisor stated all nursing staff were responsible for [redacted] care. She acknowledged CNA A should have provided resident #11's nail care when made aware the previous day. She explained [redacted] hygiene should be provided for all residents at a minimum before and after meals and on shower days. On [redacted] at 11:35 AM, the Director of Nursing (DON) stated CNAs were expected to do nail care during daily ADL care and at mealtimes. She stated nurses could also cut [redacted] or instruct CNAs to perform nail care as indicated. The DON	F 677		

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acknowledged resident #11's nails should have been trimmed by CNA A when she was made aware of the issue the previous day.

On [redacted] at 2:50 PM, the DON confirmed the CNA Kardex did not list nail care as a specific task as it was considered an expectation of basic personal hygiene care.

Review of the job description for "Certified Nursing Assistant" dated [redacted], revealed the CNA would provide routine daily nursing care. The CNA's essential job functions included, "Assist patients/residents with Activities of Daily Living such as bathing, [redacted], grooming, eating, transferring, ambulating, toileting, and other resident needs."

Review of the job description for "Registered Nurse" dated [redacted], revealed the RN would "provide direct nursing care to residents and supervise day-to-day nursing activities performed by nursing assistants. . . ."

The facility's policy and procedure for "Nail Care" dated [redacted] read, "The purpose of this procedure is to provide guidelines for the provisions of care to a resident's nails for good grooming and health." The guidelines included. . . ."3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis; 4. Routine nail care, to include trimming and filing, will be provided as needed; and 6. Procedure: . . . .c. Gently clean underneath nails with "orange stick."

Review of the "Facility Assessment" tool revised on [redacted] revealed the facility would provide required assistance with ADL care.

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F 693 SS=D	Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Nutrition (Includes naso- and tubes, both , and endoscopic , , and 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 methods unless the resident's clinical condition demonstrates that feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of feeding including but not limited to , , , , , abnormalities, and -, , . This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to follow the Registered Dietitian's (RD) recommendations for fluid administration for 1 of 1 resident reviewed for of a total sample of 26 residents, (#280). Findings: Resident #280 was admitted to the facility on with diagnoses including difficulty swallowing, status and protein calorie	F 693	1)Flush orders for resident #280 was immediately corrected in EMAR on to reflect 4 times a day. 2)All residents with tub feeding orders were reviewed on for accuracy of transcription into EMAR. All discrepancies were addressed. 3)DON/designee to re-educate nurses on accurately transcribing verbal orders into the EMAR/ETAR, and 24 hour chart check process.	

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F 693	Continued From page 28 A ˘ ´ tube is a tube that is surgically inserted through the skin directly into the . It is used to provide nourishment and water for people who cannot swallow correctly or do not take enough food by to stay healthy (retrieved on ... from www.medlineplus.gov) Review of the Minimum Data Set (MDS) admission assessment with assessment reference date of ..... revealed resident #280 had a score of 14 which indicated she had intact cognition. The document indicated resident #280 was diagnosed with ..... and had a ..... . The assessment revealed the resident received 501 milliliters per day or more via ..... . Review of resident #280's medical record revealed a care plan for risk for fluid volume ..... initiated on ..... The interventions included administer ˘ and water flushes as ordered, and to monitor and report signs and symptoms of ´ . A ..... ˘ care plan dated ..... indicated resident #280 was dependent on ˘ and water flushes. The care plan directed nurses to follow physician orders. Review of a "Medication Review Report" revealed a physician order dated ..... to administer 125 milliliter (ml) every six hours. Review of the Medication Administration Record (MAR) dated ..... revealed nursing documentation to validate resident #280 received 125 ml of water once every shift, three times daily, instead of every 6 hours, or four times daily, as ordered.	F 693	4)Orders will be reviewed in clinical morning meeting for accuracy. Random audits of orders will be conducted weekly by the DON/designee for accuracy of transcription into EMAR/ETAR x 3 months. NHA/designee to present results of audits in monthly QAPI x 3 months for compliance or need for changes/extension beyond 3 months to POC if indicated.	

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F 693	Continued From page 29	F 693		

Review of a "Nutrition Dietary" note dated revealed a recommendation by the RD to decrease resident #280's water flushes to 125 ml every six hours.

On at 12:19 PM, resident #280 was observed with very dry , that stuck to her as she talked. Resident #280 repeatedly picked at the peeling dried skin on her , .

On at 1:24 PM, the Consultant RD explained residents that needed required water flushes as alone did not provide an adequate amount of fluid. She confirmed she reviewed resident #280's labs and made a recommendation for an appropriate amount of water flush to meet the resident's needs. The RD reviewed her progress notes and recommendations and validated resident #280 should receive 125 ml of water every six hours. She was prompted to review the MAR and acknowledged the documentation showed resident #280 received 375 ml of additional water daily instead of 500 ml required. The RD confirmed that receiving an inadequate amount of fluid could cause dry , .

On at 1:47 PM, Licensed Practical Nurse (LPN) C/Nurse Supervisor confirmed the physician ordered 125 ml water flush for resident #280 every six hours. She reviewed the medical record and confirmed nurses had been administering water once every eight-hour shift rather than every six hours as ordered. LPN C stated she was regularly assigned to resident #280 and had administered the flush once per shift as she had not noticed the discrepancy. She stated the resident could become

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F 693	Continued From page 30 without the proper amount of water administered. On at 3:31 PM, resident #280 stated she was still thirsty and her felt dry. On at 10:54 AM, Registered Nurse (RN) B acknowledged she had administered the 125 ml water flush on her shift for resident #20 but did not notice the order was entered incorrectly. The facility's policy and procedure for "Appropriate Use of " dated read, "It is a policy of this facility to ensure that a resident maintains acceptable parameters of nutritional and hydration status." Guidelines indicated residents who were dependent on would receive the appropriate treatment and services to prevent complications with including but not limited to	F 693		
F 695 SS=D	Care and Suctioning CFR(s): 483.25(i) § 483.25(i) care, including care and suctioning. The facility must ensure that a resident who needs care, including care and suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure was administered as ordered for 1 of 1 resident reviewed for care, of a total sample of 26 residents, (#12).	F 695	1) was replaced and immediately placed in nares with resident permission on . 2)Audit of current residents with	

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F 695	Continued From page 31 Findings: Resident #12 was admitted to the facility on [illegible] with diagnoses including [illegible] ( ), [illegible] { }, [illegible] aneurysm and [illegible]. Review of the Minimum Data Set (MDS) significant change assessment with assessment reference date of [illegible] revealed resident #12 had a [illegible] score of 8 which indicated she had moderate [illegible]. She did not exhibit any behavioral symptoms and did not reject care that was necessary to achieve her goals for health and well-being. The document revealed the resident experienced [illegible] when lying flat and she received [illegible]. A care plan for "Potential for ineffective breathing related to diagnosis of [illegible] and [illegible]" was initiated on [illegible]. Interventions included, "Apply [illegible] per [physician] orders, Monitor for signs/symptoms of acute [illegible] insufficiency: [illegible], Restlessness, [ ] at rest, [illegible], somnolence." Resident #12 had a care plan for behavior problems including removing [illegible] tubing that was initiated [illegible] and revised on [illegible]. The care plan did not include any intervention or approaches to address the resident's removal of [illegible] tubing. Review of "Post [illegible] Screen Assessment" dated [illegible] revealed resident had a [illegible] on [illegible] with an intervention to check the resident every two hours to "ensure patient has [illegible] on."	F 695	orders on [illegible] were reviewed for placement and compliance with wearing [illegible] with no other discrepancies found. 3)DON/designee to re-educate nursing staff administering [illegible] as ordered. 4)Weekly audits will be conducted by DON/designee for compliance in [illegible] administration per physician order x3 months. NHA/designee to present results of weekly audits in monthly QAPI x 3 months for compliance or need for changes or extension beyond 3 months to POC if indicated.	

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F 695	Continued From page 32	F 695		

Review of resident #12's medical record revealed a physician order dated ... for ... at 5 liters per minute (L/min) continuously via . An order dated ... directed nurses to check the resident's ... saturation level and assess, document and notify the physician if less than 90%.

A normal ... saturation level is 95% to 100%. Values under 90% are considered low and could cause , , , , ..., slow ... rate and ... (retrieved from www.cdc.gov).

On at 11:18 AM, resident #12 was in bed, lying flat and did not have ... in place. Resident stated she did not feel good. The ... tubing was draped over the ... concentrator approximately five away from bed on the other side of the resident's nightstand. Resident #12 was slightly and was not aware she did not have her ... in place. She said, "The staff seem to think that if I don't have it on, I will pass out and die."

On ... at 11:20 AM, Licensed Practical Nurse (LPN) C/Nurse Supervisor was informed resident #12's ... was not in place. LPN C validated the resident's was not in place and noted it was draped over the concentrator and touched the floor. She explained resident #12 was bedbound and could not have placed the that far away from the bed.

On ..... at 11:25 AM, Certified Nursing Assistant (CNA) A stated she obtained resident #12's ... saturation level earlier that morning

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F 695	Continued From page 33 and obtained a reading of 90%. She could not recall if the reading was obtained with or without [illegible] in place. CNA A was asked to check the resident's [illegible] saturation level and discovered it was 88%. On [illegible] at 11:29 AM, LPN C stated when she last saw resident #12 at 9:30 AM, the [illegible] was in place. LPN C stated resident #12 required [illegible] due to a history of [illegible] failure. She explained the resident needed continuous [illegible] at 5 L/min. She acknowledged the [illegible] should have been in place and worn continuously. On [illegible] at 10:41 AM, Registered Nurse (RN) B confirmed resident #12 was prescribed [illegible] at 5 L/min continuously but would sometimes take her [illegible] off and drop it on the floor next to the bed. RN B explained the resident needed [illegible] due to diagnoses of [illegible] and [illegible]. RN B stated without [illegible], the resident could become [illegible], disoriented and [illegible]. RN B stated an [illegible] saturation level of less than 90% was considered low and would be concerning. A review of "Progress Notes" from [illegible] through [illegible] revealed no nursing documentation regarding resident #12 removing her [illegible]. The facility's policy and procedure for "[illegible] Administration" dated [illegible] read, "[illegible] is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences." The document's guidelines indicated [illegible] was to	F 695		

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F 695	Continued From page 34 be administered according to physician orders.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 755	1)Resident # 11 was assessed by nurse	

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F 755	Continued From page 35 failed to administer [redacted] medication according to physician ordered parameters for 1 of 5 residents reviewed for unnecessary medications of a total sample of 26 residents, (#11). Findings: Resident #11 was admitted to the facility on [redacted] with diagnoses including [redacted]. Review of the Minimum Data Set admission assessment with assessment reference date of [redacted] revealed resident #11 had medically [redacted] conditions. Review of the "Order Summary Report" for [redacted] revealed resident #11 had a physician order for [redacted] 10 milligrams (mg) to be given two times a day for [redacted]. The order included parameters to hold the medication if resident #11's [redacted] rate was less than [redacted] (bpm). [redacted] is a medication which slows the rate and decreases [redacted] and the workload of the [redacted]. This medication requires [redacted] and [redacted] rate to be checked as ordered by the physician. Adverse reactions could include [redacted], drowsiness, fatigue, low [redacted] and [redacted] (retrieved on [redacted] from www.drugs.com). Review of the Medication Administration Record (MAR) for [redacted] and [redacted], revealed over a 27-day period in facility, five	F 755	and ARNP on [redacted] with no adverse effects noted to resident [redacted]s health. 2)Other current resident [redacted]s with medication containing parameters were identified and administration documentation reviewed on [redacted]/2022. Residents who were given medications outside of parameters were assessed by nurse managers with no adverse effects noted, physicians were notified and no new orders were received. 3)DON/designee to re-educate nurses on medications that contain parameters to hold administration of medication, and appropriate documentation of holding medication. 4)Biweekly audits will be completed by DON/designee for compliance in holding medications based on parameters x 3 months. NHA/designee to present results of weekly audits in monthly QAPI x 3 months for compliance or need for changes/extension beyond 3 months to POC if indicated.	

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	106118	A. BUILDING _____ B. WING _____	01/20/2022

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F 755	Continued From page 36 nurses administered to resident #11 outside of specified parameter. Documentation showed resident #11 received this medication on 9 days when his rate was less than . The medication was administered on with a , on with a , on with a , on with a , on with a , on with a , on with a , and on with a . On , resident #11's but his scheduled dose of was held despite a rate within parameter. Review of "Progress Notes" for and revealed no associated documentation for the above dates to explain why the was given and held for rate outside of the physician ordered parameter. On at 5:20 PM, the Director of Nursing (DON) reviewed resident #11's MAR and confirmed that doses of were not held according to physician ordered parameter. She confirmed the medication should have been held as it could further lower the rate. The DON explained nurses were expected to check residents' vital signs at the bedside prior to administering medications and should only administer medications according to physician orders. On at 10:59 AM, Registered Nurse (RN) B confirmed she held resident #' 11's on . She noted the medication should have been given as ordered as his rate was	F 755		

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F 755	Continued From page 37	F 755		

above . RN B acknowledged she administered on when it should have been held due to a rate. RN B said, "You don't want to administer the medication if rate is less than 60 because the medication will drop the rate even lower."

On at 11:22 AM, Licensed Practical Nurse (LPN) C/Nursing Supervisor confirmed she administered resident #11's on three occasions when it should have been held. She reviewed the medical record and acknowledged it was an error.

On at 11:35 AM, the DON stated the facility's consultant pharmacist reviewed all medications once monthly but did not identify any irregularities related to resident #11's .

Review of the "Consultant Pharmacist's Medication Regimen Review" for revealed no recommendations for resident #11.

On at 1:05 PM, during a telephone interview, the consultant pharmacist stated she periodically spot-checked medications with parameters during her monthly audits. The consultant pharmacist explained physician's ordered parameter for was to ensure the medication would be held if the rate was too low. She explained administration of this medication outside the parameter could be dangerous.

The facility's policy and procedure for "Medication Administration" dated included guidelines to ..."8. Obtain and record vital signs, when applicable or per physician orders. When

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F 755	Continued From page 38 applicable, hold medication for those vital signs outside the physician's prescribed parameters." Review of the job description for "Licensed Practical Nurse" dated , revealed essential job functions included, "Ensure that residents are receiving their medication based on doctor's orders/complete medication pass." Review of the job description for "Registered Nurse" dated , revealed the RN would provide direct nursing care. Review of the "Facility Assessment" tool revised revealed the facility would admit residents with / which included , and . The document indicated staff were trained annually on "Medication Administration."	F 755		
F 758 SS=D	Free from Unnec Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Drugs. §483.45(c)(3) A drug is any drug that affects activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) ; (ii) ; (iii) ; and ( ) Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		

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F 758	Continued From page 39 , , , , , , drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use , , , drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive , , , , , , drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for , , , drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for , , , , drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the physician showed justification for the continued use of a , , , medication (, , , , , ,) on an as needed (PRN) basis for 1 of 5 residents reviewed for unnecessary medication usage of a total sample	F 758	1)MD for resident #20 immediately contacted about PRN , , , , , , use. MD re-iterated that there was no stop date for medication, appropriate documentation placed in chart. Documentation was placed in resident : s file on , , , , , , , , , ,	

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F 758	Continued From page 40 of 26 residents, (#20). Findings: Resident #20 was admitted to the facility on with diagnoses including , and . Review of the Minimum Data Set (MDS) assessment dated revealed a Brief Interview Mental Status, ( ) of 4 indicating severe . The assessment revealed the resident did not have , , no behavioral symptoms or refusal of care. The assessment showed the resident received 10 doses of , medication from . On at 12:18 PM, resident #20 sat in recliner chair next to her bed, eating lunch, and listening to music. She was unable to answer any questions. Review of the resident's medical record revealed an active order dated for , 0.5 milligrams (mg) give 1 tablet by every 24 hours PRN for , with no stop date. Review of the medication administration record (MAR) revealed the resident continued to receive PRN, for , past the allowable 14 days. There was no documentation by the physician from to justify the continuation of past the 14 days. On at 5:39 PM, the Director of Nursing (DON) stated PRN , , medications were only for 14 days then they must be	F 758	2)Other residents receiving PRN , , medications were reviewed with no other discrepancies noted. 3)DON/designee to re-educate nurses on the 14 Day PRN , , rule and need for obtaining documentation of necessity if continued beyond 14 days. 4)PRN , , orders will be reviewed during clinical morning meeting by IDT to ensure 14 day stop date or appropriate physician documentation. DON/designee to conduct weekly audits of PRN , , , medications for compliance with 14 day stop date or documentation of need for use beyond 14 days x 3 months. NHA/designee to present results of weekly audits in monthly QAPI x 3 months for compliance or need for changes/extension beyond 3 months to POC if indicated.	

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F 758	Continued From page 41 discontinued. She added if the resident required the PRN medication longer than 14 days, the physician must provide a justification for use and the resident must be monitored by the physician and psychologist. On at 9:54 AM, the DON stated the Pharmacy Consultant checked residents' medications once per month. The DON noted resident #20's , medication order was stopped on and restarted on PRN basis on . She acknowledged the order dated had no stop date and the resident received the medication after the 14 days. She acknowledged there was no documentation from the physician for continued use of , . On at 1:06 PM, the Pharmacy Consultant indicated , , medications ordered PRN were for 14 days and required a stop date. Review of facility policy Use of , , Drugs revision date revealed Policy Explanation and Compliance Guidelines: number 8 showed "PRN orders for , , drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e.14 days). A. If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order."	F 758		