STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525466	A. BUILDING _____ B. WING _____	05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING VALLEY HEALTH AND REHAB CENTER	S830 - WESTLAND DR SPRING VALLEY, WI 54767

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This was a recertification survey conducted at Spring Valley Health and Rehab Center from 05/01/2022 through 05/04/2022. Federal citations issued: 8 The most serious citation is F880 cited at a severity/scope level of F (Potential for harm/Widespread). Census: 30 Sample Size: 12 Supplemental Sample Size: 1	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(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 psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		

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

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F 580	Continued From page 1	F 580		

(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 resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility did not immediately report to the resident's physician when a resident had a fall, with head injury, that occurred during transport in the facility van. This occurred for 1 of 1 Residents (R) reviewed, (R23.)

Findings include:

R23 was admitted to the facility on 09/30/21 with diagnoses including in part, pneumonia,

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congestive heart failure, history of seizures, and Alzheimer's disease.

On 05/01/22, at 1:41 PM, Surveyor interviewed R23's brother who reported he was told R23 slipped out of the wheelchair while being transported from an appointment. The brother stated he was informed R23 hit his head on the seat in front of him during the incident, and cut and bruised his forehead. The brother did not know any more details about the accident, but thought it occurred when R23 was being transported by facility staff in the facility van from an appointment. The brother did not know if a physician was informed or evaluated R23's injuries after the incident.

Review of R23's medical record identified the following note:

"Incident report dated 03/21/22 15:16 Type of fall: observed fall
Who observed the fall: staff member name: [Medical Records (MR) H]
Location: other: Facility van
Injury: skin tear, avulsion, hematoma forehead
Did resident hit head? yes, neuro assessment initiated
Staff involved: nurse, CNA [certified nursing assistant], RA [resident assistant], social worker
Describe event: Staff member reports resident was being transported back to facility, was slipping down in his chair, leaned forward and bumped his head on the back of the seat in front of him
Notifications: family notified: [brother]
Teaching done: other: Safe chair positioning
Shift: AM shift
Day of week: Monday

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F 580	Continued From page 3 Date of fall: 03/21/22 Time of fall: 13:30" Record review identified the following note the day after the incident: "03/22/22 08:03 Physician/NP Contact: Spoke with [physician] Results/actions: New orders received and noted, 03/22/22 Purpose for note: Writer spoke with [physician] this am, he has reported lab values of increased CHF [congestive heart failure], writer also reported incident yesterday of slipping out of w/c [wheel chair] in the van, order obtained for broda chair for safety due to poor core strength." The only other note about the incident in the medical record was five days after the incident, as follows: "03/26/22 00:55 Purpose for note: follow-up: post fall no new injuries, no c/o [complaint of] pain discomfort." Surveyor noted the physician was not immediately notified of the incident when the resident sustained a head injury. On 05/03/22, at 12:40 PM, Surveyor interviewed Registered Nurse (RN) F who was not working when the incident occurred, but was aware of the incident. RN F stated MR H was transporting R23 back from a clinic appointment in the facility van when he slid out of the wheelchair in the van. RN F was told R23 leaned forward and bumped his head on the seat in front of him during the fall. RN F did not know if the incident was investigated or when the physician was informed of the	F 580		

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incident.

On 05/03/22, at 1:27 PM, Surveyor interviewed MR H, who stated she was transporting R23 to a clinic appointment in the facility van. MR H stated they were not very far from the facility when R23 wiggled and slid down in the wheelchair. R23 was sitting on the foot rests of the wheel chair, and bumped his head on the seat in front of him. MR H reported R23 sustained a cut and bruise on the forehead from that bump. MR H turned the van around and returned to the assisted living side of the building to have a staff member help get R23 back into the wheelchair. When R23 was secured in the wheelchair, MR H transported R23 to the clinic appointment. Surveyor inquired if the physician was notified of this incident when R23 was brought to the clinic. MR H did not go in to the appointment with R23. MR H stated on the way back from the clinic, R23 did the same thing again and slid out of the wheelchair during the van transport. MR H stated other facility staff, including Director of Nursing (DON) B, assisted getting R23 back into the wheelchair when they returned to the facility.

On 05/03/22, at 2:50 PM, Surveyor interviewed DON B, who stated she was aware of this incident. DON B assisted getting R23 back into wheelchair when they returned from the clinic appointment. DON B stated R23 had a small skin tear and bruise on the forehead. Surveyor asked if the physician was informed of the incident, and if injury to the forehead was evaluated by the physician during the clinic appointment. DON B stated the incident and injury did not happen until on the way back from the clinic appointment. Surveyor informed DON B that MR H reported R23 slid out of the wheelchair and cut his

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F 580	Continued From page 5 forehead on the way to the clinic. DON B was not aware of that, and thought it happened on the way back from the clinic. Surveyor asked if the physician was notified of the incident and R23's head injury. DON B stated the physician was updated the next day, and gave orders for a broda chair due to R23's poor trunk strength. Asked if the MD should have been notified at the time of the incident, DON B stated yes probably.	F 580		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not thoroughly investigate a resident fall, with injury, that occurred during transport in the facility van. The facility did not report the incident to the	F 610		

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facility administrator in accordance with state law. This occurred for 1 of 1 Residents (R) reviewed (R23.)

Findings include:

Facility Policy titled, "Preventing Violations of Residents Rights and Resident Abuse" states in part, "...VI. IDENTIFYING. A. Spring Valley Health and Rehabilitation Center Staff are instructed to promptly report any questionable situation or concerns that could be a violation of a Resident's Rights or Resident Abuse to the Staff Person's Supervisor, Department Director, Social Services Coordinator, or the Administrator...Supervising Nurses are to complete a Resident Safety Report and submit it to the Director of Nursing Services in a timely manner. The Director of Nursing Services shall review all Resident Safety Reports taking any necessary investigative action as warranted. The Director of Nursing Services shall inform the Social Services Coordinator and Administrator of those Resident Safety Reports requiring further investigation for abuse, neglect...VII. INVESTIGATING...B. Allegations are to be recording in writing. Initial information on the allegation can be recorded on the Spring Valley Health and Rehabilitation Center's Resident Safety Report or on the Wisconsin Department of Health Services, Division of Quality Assurance, Bureau of Nursing Home Resident Care Form DSL-2448 Witness Statement. After initial information on the allegation is collected and compiled it should be reviewed immediately with the Administrator for an Administrative Investigation..."

R23 was admitted to the facility on 09/30/21 with diagnoses including in part, pneumonia,

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congestive heart failure, history of seizures, and Alzheimer's disease.

On 05/01/22, at 1:41 PM, Surveyor interviewed R23's brother who reported he was told R23 slipped out of the wheelchair while being transported from an appointment. The brother stated he was informed R23 hit his head on the seat in front of him during the incident, and cut and bruised his forehead. The brother did not know any more details about the accident, but thought it occurred when R23 was being transported by facility staff in the facility van from an appointment. The brother did not know if a physician was informed or evaluated R23's injuries after the incident.

Review of R23's medical record identified the following note:

"Incident report dated 03/21/22 15:16 Type of fall: observed fall
Who observed the fall: staff member name: [Medical Records (MR) H]
Location: other: Facility van
Injury: skin tear, avulsion, hematoma forehead
Did resident hit head? yes, neuro assessment initiated
Staff involved: nurse, CNA [certified nursing assistant], RA [resident assistant], social worker
Describe event: Staff member reports resident was being transported back to facility, was slipping down in his chair, leaned forward and bumped his head on the back of the seat in front of him
Notifications: family notified: [brother]
Teaching done: other: Safe chair positioning
Shift: AM shift
Day of week: Monday

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Date of fall: 03/21/22
Time of fall: 13:30"

Record review identified the following note the day after the incident:

"03/22/22 08:03 Physician/NP Contact: Spoke with [physician]
Results/actions: New orders received and noted, 03/22/22
Purpose for note: Writer spoke with [physician] this am, he has reported lab values of increased CHF [congestive heart failure], writer also reported incident yesterday of slipping out of w/c [wheelchair] in the van, order obtained for broda chair for safety due to poor core strength."

The only other note about the incident in the medical record was five days after the incident, as follows:

"03/26/22 00:55 Purpose for note: follow-up: post fall no new injuries, no c/o [complaint of] pain discomfort."

On 05/03/22, at 12:40 PM, Surveyor interviewed Registered Nurse (RN) F who was not working when the incident occurred, but was aware of the incident. RN F stated MR H was transporting R23 back from a clinic appointment in the facility van when he slid out of the wheelchair in the van. RN F was told R23 leaned forward and bumped his head on the seat in front of him during the fall. RN F did not know if the incident was investigated by administration.

On 05/03/22, at 1:09 PM, Surveyor interviewed Nursing Home Administrator (NHA) A about the incident, and asked if the incident was

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investigated. NHA A was not aware of this incident, and was unsure of any details of the event, or if it was investigated. NHA A stated this would be a serious enough event that would warrant investigation. NHA A stated this would be looked into now.

On 05/03/22, at 1:27 PM, Surveyor interviewed MR H, who stated she was transporting R23 to a clinic appointment in the facility van. MR H stated they were not very far from the facility when R23 wiggled and slid down in the wheelchair. R23 was sitting on the foot rests of the wheelchair, and bumped his head on the seat in front of him. MR H reported R23 sustained a cut and bruise on the forehead from that bump. MR H turned the van around and returned to the assisted living side of the building to have a staff member help get R23 back into the wheelchair. When R23 was secured in the wheelchair, MR H transported R23 to the clinic appointment. Surveyor inquired if the physician was notified of this incident when R23 was brought to the clinic. MR H did not go in to the appointment with R23. MR H stated on the way back from the clinic, R23 did the same thing again and slid out of the wheelchair during the van transport. MR H stated other facility staff, including Director of Nursing (DON) B, assisted getting R23 back into the wheelchair when they returned to the facility. MR H was unsure if the incident was investigated, or who the incident was reported to.

On 05/03/22, at 2:50 PM, Surveyor interviewed DON B, who stated she was aware of this incident. DON B assisted getting R23 back into wheelchair when they returned from the clinic appointment. DON B stated R23 had a small skin tear and bruise on the forehead. Surveyor asked

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F 610	Continued From page 10 if the physician was informed of the incident, and if injury to the forehead was evaluated by the physician during the clinic appointment. DON B stated the incident and injury did not happen until on the way back from the clinic appointment. Surveyor informed DON B that MR H reported R23 slid out of the wheelchair and cut his forehead on the way to the clinic. DON B was not aware of that, and thought it happened on the way back from the clinic. Surveyor asked if the incident was investigated to determine how to protect R23 from further incidents. DON B stated they did discuss the incident and decided not to transport R23 in the facility van in the future, but there was no documentation of any investigation of the incident, or notification of the facility administrator.	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure Minimum Data Set (MDS) assessments accurately reflected resident's status at the time of assessment for 3 of 12 Residents (R) reviewed, (R15, R23, and R126.) R15 and R23's most recent MDS assessments identified both residents as having a significant weight loss, but the weights recorded on the medical records did not show significant weight loss. R126's admission MDS assessment identified	F 641		

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R126 as having an unhealed stage 2 pressure injury, but the medical record and interviews did not show R126 had a stage 2 pressure injury.

Findings include:

Example 1:

R15 was admitted on to the facility on 07/13/1998, with diagnoses including in part, cerebral palsy, epilepsy, Rett's syndrome, and severe intellectual disabilities.

Surveyor reviewed form CMS-802 Matrix for Providers which listed R15 as having excessive weight loss without prescribed weight loss program.

The most recent Minimum Data Set (MDS) assessment dated 03/11/22, Section K Swallowing/Nutritional listed R15's weight 158 pounds and indicated R15 had a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months.

Surveyor identified the following weights recorded on R15's medical record:

09/22/21 162 pounds
11/23/21 169 pounds
12/07/21 158 pounds
01/04/22 161 pounds
03/29/22 161 pounds
04/26/22 164 pounds

On 09/22/2021, the resident weighed 162 pounds. On 03/29/2022, the resident weighed 161 pounds which was a -0.62 % loss in 6 months.

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On 12/07/2021, the resident weighed 158 pounds. On 01/04/2022, the resident weighed 161 pounds which was a 1.90 % gain in one month.

Since 12/07/21 to the most recent weight, R15 had a 6 pound weight gain, but the most recent MDS assessment and Matrix for Providers form both still indicate R15 had excessive weight loss.

On 05/03/22, at 8:05 AM, Surveyor interviewed Director of Nursing (DON) B. Surveyor asked why R15 was listed on the Matrix and most recent MDS assessment as having excessive weight loss, when the weights on the medical record do not show a significant weight loss. DON B was not sure why it was documented that way. DON B stated R15's weight had been stable for the past several months. DON B was not sure if the MDS assessment was coded correctly because R15's weight had been stable and R15 did not meet criteria for significant weight loss.

On 05/03/22, at 11:11 AM, Surveyor interviewed Registered Nurse (RN) F who completed the MDS assessments. RN F reported the weight data was pulled from the electronic medical record when beginning the MDS assessments. RN F stated the system flags if there was a significant weight loss, and then RN F would code the MDS assessment as such. RN F was not sure why the system would flag for a significant weight loss if there was not one.

Example 2:

R23 was admitted to the facility on 09/30/21 with diagnoses including in part, pneumonia,

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congestive heart failure, history of seizures, and Alzheimer's disease.

Surveyor reviewed form CMS-802 Matrix for Providers which listed R23 as having excessive weight loss without prescribed weight loss program.

Surveyor identified the following weights listed on R23's medical record:

10/12/21 221 pounds
10/13/21 223 pounds
10/15/21 220 pounds
10/23/21 221 pounds
10/24/21 224 pounds
10/26/21 225 pounds
11/18/21 225 pounds
11/22/21 224 pounds
11/24/21 222 pounds
11/27/21 223 pounds
12/01/21 223 pounds
12/18/21 223 pounds
12/21/21 215 pounds
01/02/22 219 pounds
01/04/22 231 pounds
01/12/22 231 pounds
01/19/22 231 pounds
02/06/22 221 pounds
04/04/22 218 pounds

The significant change MDS dated 04/05/22 Section K Swallowing/Nutrition listed R23's weight as 218 pounds, and indicated R23 had a weight loss of 5% or greater in the past month or 10% or greater in the past 6 months not on a physician prescribed weight-loss program.

Record review showed on 10/12/2021, R23

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weighed 221 pounds. On 04/04/2022, R23 weighed 218 pounds which is a -1.36 % loss in 6 months. On 02/06/2022, R23 weighed 221 pounds. On 04/04/2022, R23 weighed 218 pounds which was a -1.36 % loss in 2 months. There was no weight recorded on R23's medical record for the month of March.

On 05/03/22, at 8:05 AM, Surveyor interviewed Director of Nursing (DON) B. Surveyor asked why R23 was listed on the Matrix and most recent MDS assessment as having excessive weight loss, when the weights on the medical record do not show a significant weight loss. DON B stated R23 did have weight loss in December, but weights improved with dietary changes. DON B stated R23 also had weight gain due to fluid retention from congestive heart failure, but R23's weight had been stable for the past couple of months. DON B did not think the most recent MDS assessment was coded correctly because R23 did not meet criteria for significant weight loss.

Example 3:

R126 was admitted to the facility on 04/12/22 with a diagnosis of long term history of traumatic brain injury following a brain aneurysm.

Surveyor reviewed form CMS-802 Matrix for Providers which listed R126 as having a stage 2 pressure injury.

On 05/01/22, at 11:38 AM, Surveyor interviewed R126's son, who said R126 did not have any current open sores on her skin and did not have any open sores when admitted to the facility. R126's son reported R126 had red areas that

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come and go, but had not had any open sores.

Surveyor reviewed R126's medical record and did not identify any documentation of unhealed pressure injuries on admission assessment, or on any skin assessment documentation since admission to the facility.

The admission MDS, dated 04/18/22, stated under Section M Skin: Yes: unhealed pressure ulcers/injuries. Two stage 1 pressure injuries, and one stage 2 pressure injury.

On 05/02/22, at 7:10 AM, Surveyor interviewed RN D, who reported R126 did not have any current unhealed pressure injuries, and did not ever have any pressure injuries since admission.

On 05/03/22, at 7:47 AM, Surveyor interviewed DON B, who stated they assisted with the skin assessment for R126 at the time of admission. DON B stated R126 had red areas on her bottom, but no open pressure injuries. They were told by the resident's son and hospice nurse at the time of admission that R126 had red areas that come and go, but did not currently have any open pressure injuries. DON B stated since admission to the facility, R126 had not developed any open pressure injuries. DON B stated the MDS assessment was coded incorrectly.

On 05/03/22, at 11:11 AM, Surveyor interviewed RN F, who reported she thought R126 had a stage 2 open pressure injury when she admitted to the facility, so that is why the MDS was coded that way. RN F would look for documentation on the medical record.

On 05/03/22, at 12:51 PM, RN F reported to

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F 641	Continued From page 16 Surveyor after reviewing R126's medical record, RN F remembered seeing R126's red bottom with an open slit and and that was why RN F coded the MDS assessment with a stage 2 pressure injury. RN F stated she did not document that assessment of an open area anywhere in R126's medical record, did not notify a physician of the open wound, or get orders for treatment of an open wound. RN F stated R126 did not currently have an open wound.	F 641		
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 psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights 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	F 656		

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rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility did not develop and implement a comprehensive person-centered care plan for each resident.

The facility did not develop a care plan for bleeding risk for residents receiving anticoagulant medications for 2 of 5 Residents (R) receiving anticoagulant medications (R3, R21.)

Findings include:

Facility Policy and Procedure Subject: Warfarin (Coumadin) Anticoagulation Monitoring Protocol stated, in part:
"...G. Physician notification is required and requested for follow up INR [International Normalized Ratio] made when a significant 1. Change in nutritional status specific to when a resident stops eating, has nausea or vomiting, starts IV [intravenous] therapy, supplements are added or when symptoms present including bruising, bleeding from the gums with teeth

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brushing, nosebleeds, blood in the stool, sudden onset of confusion that may include bleeding into the brain, or changes in breathing pattern or lung sounds that may indicate blood in the lung (s)."

Example 1:

R3 was admitted on to the facility on 11/18/20 with diagnoses including in part, obsessive compulsive disorder, type 1 diabetes, and venous thrombosis.

Review of R3's medical record identified the following physician orders:

04/06/22 Warfarin Sodium [anticoagulant medication] 7.5 mg [milligrams], one tablet daily every Monday, Wednesday and Friday.
04/06/22 Warfarin Sodium 5 mg, 1 tablet daily every Sunday, Tuesday, Thursday, and Saturday.

Surveyor reviewed the nursing orders on R3's medical record. No nursing orders were identified to monitor resident for signs of abnormal bruising or bleeding.

Surveyor reviewed R3's comprehensive care plan. No care plan was identified to monitor for bleeding risk due to anticoagulant therapy.

On 05/03/22, at 2:46 PM, Surveyor interviewed Director of Nursing (DON) B, who stated there was no anticoagulant care plan on R3's record. DON B stated there should be an anticoagulant care plan on this resident's record so that staff are aware of the risk for bleeding.

R21 was admitted to the facility on 10/19/21, and has diagnoses that include pulmonary embolism,

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F 656	Continued From page 19 anxiety disorder, panic disorder, diabetes, dementia, and major depressive disorder. R21 is on an anticoagulant (AC) than can cause bleeding. Upon record review, Surveyor reviewed R21's care plan and there was nothing in the care plan that indicated R21 was on a blood thinner and what side effects staff should be watching for. On 05/03/22 at 1:10 pm, Surveyor interviewed Registered Nurse (RN) D and asked if the treatment authorization request (TAR) had anything to monitor for side effects from taking an AC. RN D looked in R21's electronic chart and said there was nothing on the TAR. On 05/03/22 at 1:15 pm, Surveyor interviewed DON B and asked if there was anything in the resident's file that would have orders to monitor for side effects of being on an AC. DON B indicated not that she knew of. Surveyor asked if there was anything in the resident's care plan that would indicate to monitor for side effects from an AC, DON B shook her head no. On 05/03/22 at about 1:20 pm, Surveyor interviewed RN F and asked if there was a process in place for staff to watch for side effects of a resident that takes an AC. RN F indicated nothing specific for an anticoagulant.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		

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§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on interviews and record reviews, the facility did not ensure adequate supervision to prevent accidents for 1 of 1 residents (R) (R2) reviewed for smoking and 1 of 3 residents (R3) reviewed for falls.

R2 goes outside without supervision and keeps cigarettes and lighter in the room. No smoking assessment or care plan was is in place for smoking.

The facility did not investigate falls for root cause or put new interventions in place to prevent future falls for R3.

This is evidenced by:

Example 1:

The facility policy, entitled, "Tobacco-Free Policy" states: "... Residents and tenants will not be permitted to use tobacco or smoke under any circumstances, if an employee observes a resident/tenant using tobacco products need to remind the tobacco user of the policy and provide an informational card. Residents and tenants tobacco items will be placed in a secure location until dismissal..."

R2 was admitted to the facility on 11/16/20, and has diagnoses that include Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side.

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R2's Minimum Data Set (MDS) assessment dated 02/03/22, indicated Brief Interview for Mental Status (BIMS) of a score of 10.

R2's Care Plan dated 11/16/21, states intervention, "Resident is aware and is educated on negative effects of smoking. Resident is able to smoke outside Ind. In the designated smoking area and will follow all facility smoking rules.

On 05/02/22, at 02:27 PM, Surveyor went out with R2 when R2 went to smoke. R2 has an electric wheelchair. R2 left his room and went down the hallway to the door that R2 goes out to smoke. R2 went past the door and then turned around so R2 was able to push the handicap button to get out the first door. Once the button was pushed, R2 proceeded out the door and pushed the handicap button on the way to open the second door. R2 was outside, went next to the column where there is a tin can where R2 can put his cigarette butts. R2 took out a cigarette and took the lighter and lit the cigarette. Surveyor asked what R2 does in the winter when it is cold and stated that R2 sits closer to the building. Surveyor asked how many times R2 goes outside and R2 stated four to five times a day. Surveyor asked if staff know when R2 goes outside and R2 said that he doesn't have to tell staff that he is going outside. R2 stated that where the facility wants them to smoke it is windy and dumb. R2 stated that he feels safe where he smokes. R2 returned back into the building at 2:40 p.m. with Surveyor and went back to his room.

On 05/02/22, at 08:53 AM, Surveyor interviewed Registered Nurse (RN) D, who stated that R2 doesn't have a schedule or pattern when he goes

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out to smoke. R2 keeps his own cigarettes and lighter in his room.

On 05/03/22, at 11:58 AM, Surveyor interviewed Certified Nursing Assistant (CNA) C, who stated that R2 comes over if R2 drops his cigarettes. R2 comes over to the other side of the building and asks for help to pick them up. When CNA C goes over to the other side of the building to check on residents, if R2 is not in the room, then CNA C goes by the door to check to see if R2 is ok.

On 05/03/22, at 02:50 PM, Surveyor interviewed DON B. When asked if there was any assessment for smoking, DON B stated that there is no assessment for smoking. Surveyor asked about a care plan for R2's smoking. DON B stated that there was no care plan. DON B confirmed that R2 keeps his lighter and cigarettes in his room.

Example 2:

R3 was admitted to the facility on 11/18/20, and has diagnoses that include: diabetic, Obsessive-compulsive disorder, and major depressive disorder, and R3 has an activated power of attorney (POA).

On 4/23/22, R3 had an unwitnessed fall in his bathroom with no apparent injury.

On 3/27/22, R3 had an unwitnessed fall trying to self transfer from wheelchair to recliner with no apparent injury.

On 1/27/22, R3 had an unwitnessed fall trying to self transfer from toilet to wheelchair with no

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F 689	Continued From page 23 apparent injury. On 05/02/22, Surveyor asked DON B for the last 3 fall reports for R3. DON B provided Surveyor with the nursing notes on the last 3 falls. Review of the nursing notes does not document any investigation that was done to determine the root cause of the fall, does not document any neuro checks were completed at the time of the fall, nor any notes on any follow up of neuro checks. Notifications were made for the fall on 01/27/22 to the doctor and hospice. On 05/03/22 at 3:30 pm, Surveyor interviewed Registered Nurse (RN) F and asked if an investigation is done on falls and where the investigation could be reviewed. RN F indicated they do a follow up investigation to the falls but she did not know where that would be documented. Surveyor asked for any investigations the facility would have for the last 3 falls. On 05/03/22 at about 4:00 pm, RN F brought Surveyor 3 fall reports. The fall reports had the same information as the nursing notes did. No additional information was included in them. No new interventions were implemented or any root cause analyses were conducted for the falls to prevent future falls from occurring.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		

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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 did not ensure accurate administering of drugs.

The facility did not follow doctor's orders to discontinue Risperdal for 1 of 1 residents (R3) reviewed.

R3 was admitted to the facility on 11/18/20, and has diagnoses that include: diabetes, Obsessive-compulsive disorder, and major depressive disorder.

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F 755	Continued From page 25 Surveyor reviewed a pharmacy medication regimen review note dated 11/04/21 that read in part.... it is noted that Doctor of Medicine (MD) I signed an order on 10/08/21 to discontinue the residents Risperdal 0.5 mg at h.s, however it appears that this medication continues to be administered as indicated on the medication administration record (MAR) Surveyor reviewed the doctor's order that was scanned in the electronic medical record for R3 dated 10/06/21 that read, "Discontinue Risperdal 0.5mg at HS per consultant pharmacist recommendations." On 12/02/21 the next pharmacy review note read in part.... it is noted that this resident's Risperidone was DC'd on 11/5 subsequent to MD I orders. On 05/03/22 at about 3:00 pm, Surveyor interviewed Registered Nurse (RN) F showing her the October MAR and asked what it meant if there was a time stamp on the MAR for the Risperidone. RN F indicated that the medication was given. Surveyor reviewed R3's MAR for the months of October and November. Risperidone 0.5 mg tablet is documented as being administered the month of October through November 04, 2021, when it had been discontinued on 10/06/21.	F 755		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

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(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility did not maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections, such as COVID-19. This has the potential to affect all residents.

Facility did not ensure all staff wore appropriate personal protective equipment (PPE) when entering a resident room that was under contact and droplet precautions for 3 separate observations.

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Observations were made of staff and visitors not wearing face masks covering nose and mouth in resident common areas.

Findings include:

According to CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 (COVID-19) Spread in Nursing Homes, staff caring for residents in quarantine should wear all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.

On 05/01/22, at 12:46 PM, Surveyor observed signs on the outside of the door to Resident (R) 125's room. The signs stated contact and droplet precautions, and listed what PPE staff needed to put on prior to entering the room.

On 05/01/22, at 12:50 PM, Surveyor asked Registered Nurse (RN) N if R125 was on Transmission Based Precautions (TBP). RN N stated R125 was on quarantine to rule out COVID-19 following hospitalization, but R125 had tested negative so far for COVID-19.

On 05/01/22, at 12:58 PM, Surveyor observed Certified Nursing Assistant (CNA) G answer a call light in R125's room. CNA G was wearing a surgical face mask and eye protection when entering the room. CNA G did not put on a gown, N95 respirator, or gloves prior to entering the room. Surveyor observed CNA G use hand sanitizer at the doorway prior to leaving R125's room. Surveyor observed CNA G began walking

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down the hallway with same surgical face mask and eye protection that were worn in R125's room. Surveyor asked CNA G if R125 was on TBP. CNA G was unsure, but looked at the signs and stated maybe. Surveyor asked CNA G what PPE should be worn in the room if the resident was on contact and droplet precautions. CNA G stated just a face mask and eye protection, but was unsure and would go ask a supervisor.

On 05/01/22, at 1:03 PM, Surveyor observed Nursing Home Administrator (NHA) A talk to R125 from the doorway with a face mask and eye protection on. R125 was having difficulty hearing NHA A from the doorway, so NHA A walked farther into the room to talk to the resident without putting on additional PPE. Surveyor then observed NHA A leave the room and walk down the hallway with the same surgical face mask and eye protection on.

On 05/02/22, at 7:22 AM, Surveyor observed RN D enter R125's room to administer medications. RN D was wearing a surgical face mask and eye protection. RN D did not put on a gown, N95 mask, or gloves prior to entering the room. RN D assisted R125 to transfer from the wheelchair back to bed. RN D used hand sanitizer before leaving the room, and returned to the medication cart with the same surgical face mask and eye protection on that were worn in R125's room. R125 was reporting feeling short of breath, so RN D took the pulse oximeter from the medication cart and went back in to R125's room to check his oxygen saturation. RN D placed the pulse oximeter on R125's finger. RN D did not put on a gown, gloves, or N95 mask prior to entering the room. After checking R125's oxygen saturation, RN D came out of resident room and placed the

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pulse oximeter on the medication cart. Surveyor did not observe RN D sanitize the pulse oximeter prior to placing it on the cart. Surveyor did not observe RN D change the surgical mask or sanitize or change the eye protection after being in R125's room. Surveyor asked RN D if R125 was on TBP. RN D was not sure, but thought they said in report R125 was vaccinated, so he would not need to be on precautions. Surveyor pointed out the contact and droplet precautions signs on R125's door. RN D stated since R125 was just in the hospital, maybe he did need to be on precautions. RN D stated she would ask Director of Nursing (DON) B about it. Surveyor asked RN D what the procedure was for multi-use equipment. RN D stated they wipe them with sanitizer wipes that are kept on the medication cart after each use. RN D stated if a resident is on TBP, they kept a basket of equipment in the resident's room for use.

On 05/03/22, at 2:59 PM, Surveyor interviewed DON B about above observations of staff entering R125's room without putting on required PPE. DON B confirmed R125 was on droplet and contact precautions to rule out COVID-19 due to unvaccinated status and recent hospitalization. DON B stated all staff should put on a gown, gloves, N95 mask, and eye protection prior to entering the room, and should remove and discard before leaving the room. The mask should be changed and the eye protection should be sanitized after leaving the room.

On 05/01/22 at 10:08 AM, Surveyor observed resident (R) 9 had 2 visitors in dining area; 1 visitor had no mask and the other visitor had a mask below his nose. The visitor with no mask on was observed filling up R9's glass with ice water.

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There were 6 other residents in the dining room at this time.

On 05/03/22 at about 9:25 AM, Surveyor interviewed Registered Nurse (RN) E and asked what type of PPE visitors were required to wear. RN E indicated a surgical mask.

Surveyor observed a sign posted on the entrance door that read in part.... for your safety and ours masks are required while on these premises.

On 05/02/22 at 12:27 PM, Surveyor observed Environmental Assistant J in the hallway outside of suite B5 and B6 talking on phone with mask on his chin.

On 05/02/22 at 1:20 pm, Maintenance staff K was observed by Surveyor touring the facility with life safety people wearing his mask below his nose.

On 05/02/22 at about 3:00 pm, Surveyor interviewed RN F and asked if staff are to wear a mask that covers the nose and mouth. RN F indicated they better be or come and get me. Surveyor told RN F that there was an example in the hallway. RN F followed Surveyor out into the hallway where maintenance staff K was talking with NHA A with his surgical mask below his nose. RN F went up to staff and motioned to maintenance staff K to pull mask up which Maintenance staff K then did. Surveyor went to the conference room and came back into the hallway where Maintenance staff K and NHA A were standing and Maintenance staff K had his mask below his nose again and did not attempt to pull it back up when Surveyor came into the hallway.

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§483.80(i)
COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct

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contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents;
(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;
(iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section;
(v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC;
(vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;
(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff

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F 888	Continued From page 34 COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section	F 888		

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are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility did not ensure all staff who provide care to it's residents were fully vaccinated for COVID 19.

Two Certified Nursing Assistant (CNA) students were not vaccinated for COVID 19 nor had an approved exemption prior to working with residents.

Findings Include:

On 05/03/22, Surveyor reviewed the vaccination status for all staff. Review of the facility's vaccination data noted a total of 72 staff with 70 staff partially, fully, temporarily delayed, or exempted from vaccinations. This calculates to 97.2% staff vaccination rates. CNA student L and CNA student M were marked as temporary delay per CDC/new hire.

On 05/03/22 at 9:20 am, Surveyor interviewed registered nurse (RN) E who is also the Nurse Educator and Infection Preventionist and confirmed the 2 students are currently in the CNA program. RN E indicated yes they were. Surveyor asked if the students have worked on the floor. RN E indicated yes they have for clinicals. Surveyor asked RN E if either of the students have had at least a single dose of the COVID 19 vaccination. RN E indicated no. Surveyor asked

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if either of the students had an exemption on file. RN E indicated there is no exemption on file.

On 05/03/22 at 9:54 am, Surveyor interviewed NHA A and asked if the CNA students do clinicals on the floor. NHA A indicated yes. Surveyor asked NHA A if he was aware of the vaccination status of the 2 students. NHA A indicated he did not know that. Surveyor asked what is expected of new staff as far as the COVID 19 vaccination before starting work in the facility. NHA A indicated he would expect that staff are vaccinated or have gotten at least 1 dose of the vaccination before they start, if not vaccinated or an exemption on file. NHA A indicated staff would be put on administrative leave until vaccinated or an exemption is on file. Surveyor asked NHA A if he had a pending exemption for either of the students. NHA A indicated he was not aware of any exemption on file for either of them.

The facility has not had any COVID positive residents in the past 4 weeks.