STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA OF BILLINGS	1807 24TH ST W BILLINGS, MT 59102

(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	F 000		

A Recertification/Complaint survey was completed by the Department of Health and Human Services, Office of Inspector General, Certification Bureau, on 2/17/22. Facility Reported Incidents were investigated during the survey.

The facility census on entrance was 61.

DEFICIENCIES CITED:
Refer to FORM CMS-2567; Event ID: 9IFU11 for findings.

Deficient practices were cited for the Recertification survey.

Deficient practices were cited for the complaint(s) with Intake number(s): MT 52027

Deficient practices were cited for Facility Reported Incident(s) with Intake Number(s): MT 51289, MT 51264, MT 51366, MT 51303, MT 51304

DEFICIENCIES NOT CITED:
Refer to FORM CMS-2567; Event ID: 080D11 for findings.

Deficient practices were NOT cited for Facility Reported Incident(s) with Intake Number(s): MT 51433, MT 51550

GLOSSARY:

ADL Activities of Daily Living
ARD Assessment Reference Date

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

Electronically Signed | 03/13/2022

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F 000	Continued From page 1	F 000		

ASP Antibiotic Stewardship Program
BID Bis In Die (twice a day)
CDC Centers for Disease Control
CNA Certified Nursing Assistant
CMP Comprehensive Metabolic Panel
COVID-19 Coronavirus Disease 2019
CVA Cerebrovascular Accident
d/c Discharged
DON Director of Nursing
EMAR Electronic Medication Administration Record
EMR Electronic Medical Record
HCP Healthcare Personnel
IDT Interdisciplinary Team
IV Intravenous
lbs Pounds
MAR Medication Administration Record
MD Medical Doctor
MDS Minimum Data Set
mg Milligram
MVI Multivitamin
NS Normal Saline
oz Ounce
PHQ Patient Health Questionnaire
po Per Oral (by mouth)
PPE Personal Protective Equipment
PRN Pro Re Nata (as needed)
PT/INR Prothrombin Time/International Normalized Ratio
QAPI Quality Assurance Performance Improvement
RD Registered Dietitian
r/t Related to
SBAR Situation Background Assessment Recommendation
SS Social Services
ST Speech Therapist
TAR Treatment Administration Record
TID Ter In Die (three times a day)

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F 000	Continued From page 2 UDA User-Defined Assessments	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		4/3/22

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F 584	Continued From page 3 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a comfortable and safe environment for 3 (#s 12, 17, and 43) of 15 sampled residents. The residents were given space heaters to heat their rooms because the radiators were not working. This deficient practice caused resident #12 to complain of being cold, resident #17 to complain of being cold, resident #43 to complain of "freezing and having a headache and sore throat," and the heaters had the potential to cause harm to the residents. Findings include: During an interview on 2/14/22 at 3:56 p.m., resident #12 stated, "The heater only works part of the time." During an interview on 2/15/22 at 8:45 a.m., resident #12 stated, "It got cold in here last night. They took my heater away and didn't bring it back. Probably because you are here." During an interview on 2/15/22 at 10:03 a.m., resident #43 stated, "I didn't have any heat in this room for three days, we had portable heaters in here until last night and they took it away. I'm freezing in here. I have a terrible headache and sore throat. I'm just so cold and it was so cold in here last week." During an interview on 2/15/22 at 10:12 a.m., staff member B stated, "The space heaters were	F 584	1.Midland Mechanical was called and evaluated heating system on 2/24/2022 to ensure heat was being delivered to each resident room. 2.All residents have the potential to be affected. 3.All space heaters removed by maintenance on or before 4/3/2022. DON or designee Education to all staff regarding safety of space heaters and facility protocol to not use space heater on or before 4/3/2022. 4.Maintenance Director or designee will conduct randomized audits three times per week in 5 resident rooms for 4 weeks, then 5 resident rooms weekly for 4 weeks, then 10 rooms monthly for 2 months to ensure no space heaters are in use and the resident's room is maintained at a comfortable temperature for the resident. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 584	Continued From page 4 removed yesterday because of life safety code." During an interview on 2/15/22 at 2:40 p.m., staff member A stated, "There is no policy for portable heaters because they are not to be used." During an interview on 2/16/22 at 8:42 a.m., staff member CC stated, "The heaters were here from around October (2021). Whenever it got cold." During an observation and interview on 2/16/22 at 2:32 p.m., staff member E came down the 300 hall checking temperatures of the radiators. He stated that he was working on the heat. He said that the system was producing heat, but it was not coming out of the radiators. The thermostat read 71 degrees Fahrenheit at the nurses' station, and it felt colder at the end of the hall by the door to the outside. During an observation and interview on 2/16/22 at 2:34 p.m., resident #17 was in her room laying on the bed wearing her robe as a blanket, she said, "It is cold in here because they had to take the heaters out because the state inspectors are here."	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		4/3/22

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F 600	Continued From page 5 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to: - Provide ordered dressing changes for 2 (#s 5 and 212) of 3 sampled residents. For #5, the resident missed a wound care appointment, which was not rescheduled, and the wound was not treated as ordered. For resident #212, a wound went untreated, and worsened, requiring antibiotics, and the resident had pain from the wound. - Nursing staff neglected to send 1 (#12) resident to the emergency department when the resident requested to be sent, and the resident was later diagnosed with lower lobe pneumonia and antibiotics to treat the infection. - Failed to protect 1 (#4) of 1 sampled residents from two incidents of verbal abuse by staff. The failure, and action taken by the facility, did not ensure resident protection after the first incident of verbal abuse for resident #4, and it occurred again. Findings include: 1. A record review of a facility reported incident for a neglect allegation, dated 9/19/21, showed, "On 9/17/21, it was reported by the wound nurse that the dressing to resident, [#5], was dated 9/9/21. Resident's dressing is scheduled to be changed on Tuesdays and Fridays. Per the schedule the dressing should have been changed on 9/10 and 9/14." The allegation of neglect was	F 600	1. Resident #5 discharged on 2/20/2022. After the allegation the resident was seen wound clinic on 9/21/2021. Resident #4-for allegation on 8/2/2021 an investigation was completed, staff suspended, and staff educated. For allegation on 10/20/2021 staff suspended, report investigated, and staff educated. Resident #212 discharged on 9/29/2021. After investigation nurse identified as falsifying documents was educated. Wound care was provided to the resident. Resident #12 due to report from during survey an investigation started. Resident was seen by provider on 1/24/2022 and denied needed services on 2/16/2022. 2.DON or designee will conduct an audit of all residents receiving wound care consultation outside of facility will be conducted and completed on or before 4/3/2022. The facility identified any missed appointments and current scheduled appointments for accuracy on or before 4/3/2022. An audit of all residents for last 30 days, was conducted to ensure completion and documentation of dressing changes was completed on or before 4/3/2022. DON or designee will conduct an interview of residents on rehab unit to ensure residents who are requesting to be	

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F 600	Continued From page 6 substantiated by the facility. During an interview on 2/16/22 at 9:56 a.m., staff member A stated she investigated the incident and found that resident #5 missed her appointment for wound care because she was not ready to go when the bus was ready to take her. The driver had another resident to take to an appointment and did not have time to wait for the nurses to get the resident ready for her appointment. Resident #5 would have had her dressing changed at that appointment, but since she did not go, the dressing was not changed. The TAR did not prompt the nurse to change the dressing. Staff member A stated they have changed the process so that on wound care appointment days it will need to be documented if the clinic does the dressing change or if the nurse does the dressing change. Although the resident did not attend the scheduled appointment, the facility staff did not ensure the resident's skin care needs were addressed related to the dressing change. A record review of resident #5's EMR, Skin Wound Note, dated 9/7/21, showed, "Resident right lateral outer and calf are healing with no signs of infection noted, redness is resolved, area is light pink, will continue with current treatment order for protection." This was prior to the event of the resident not attending the scheduled appointment. A record review of resident #5's EMR, Communication with Resident Family, dated 9/17/21, showed, "Family was notified of resident missing wound care appointment on 9/14/21. Due to the resident missing her appointment her wound care to the right calf was not completed."	F 600	transferred to hospital are transferred was completed by 4/3/2022. DON or designee will conduct staff interviews of all residents regarding feelings of abuse, concerns of abuse, and who to report abuse was completed on or before 4/3/2022. For residents who are unable to communicate and/or be interviewed, staff will be interviewed instead, for feelings of abuse, concerns of abuse, and who to report abuse. 3.Facility hired wound nurse on 3/8/2022. The facility created a transportation program to include, scheduling of appointments, master schedule, notification to staff and resident of upcoming appointments, and follow up from appointments. All staff educated on abuse prevention and reporting and effective communication by DON or designee on or before 4/3/22. Nursing staff educated by DON or designee on wound care orders, transfer requests, and transportation/appointment system. All education will be complete prior to 4/3/2022. 4.DON or designee will conduct an audit of 25% of resident with wounds weekly for 4 weeks to ensure completion of dressing, wound care follow up, and documentation, then 25% of resident biweekly, and 25% of residents monthly until sustained compliance achieved. An audit of wound care appointments weekly for scheduling, attendance, and follow up for future appointments weekly for 12 weeks until sustained compliance achieved. DON or designee of the facility will conduct random interviews of	

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F 600	Continued From page 7 2. During an interview on 2/14/22 at 3:56 p.m., with resident #12 and NF3, resident #12 stated, "I needed to go to the hospital (1/16/22) because I couldn't breathe and the nurse (staff member II), told me 'We don't do that here.'" NF3 stated she did not get a phone call about it, and that they diagnosed him (resident #12) with left lower lobe pneumonia. NF3 did not find out about it until the next day. Resident #12 stated, "The doctor saw me here the next day during his regular rounds. I was given a nebulizer and a steroid." NF3 stated, in November, around the 11th (2021) she saw protective dressings on his feet that had been on since he had been in the hospital. NF3 stated the CNA gave him a shower with the dressings on, and then the water from the wet dressings soaked his socks and shoes. NF3 went to talk to the nurse to see if she could take the dressings off and was told by the nurse, "I don't care what you do." During an interview on 2/15/22 at 2:41 p.m., staff member A stated, "We follow the resident rights on change in condition, if he (resident #12) wanted to go to the hospital, he should have been sent." During an interview on 2/16/22 at 8:36 a.m., staff member CC stated if a resident tells her they need to go to the hospital, she would check the residents' vitals, call the MD, and provide any interventions needed for the resident. Staff member CC stated, "But if the resident is requesting to go to the emergency room then I would send them." A review of resident #12's medical record showed an x-ray, dated 1/17/22, with clear lungs, and the	F 600	residents on rehab unit to ensure hospitalization requests met, 5 residents weekly for 4 weeks, then 3 residents weekly for 4 weeks, then 5 residents monthly for 2 months until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 600	Continued From page 8	F 600		

lab testing was negative for influenza and Covid 19. On 1/24/22, a new x-ray showed the resident had left lower lobe pneumonia, and a Z pack (azithromycin) was ordered, along with prednisone 40 mg for 5 days, and Duo Neb three times a day, to be started 1/24/22. Review of resident #12's MAR showed the medications were not started until 1/25/22.

During an interview on 2/16/22 at 2:38 p.m., resident #12 stated, "I did tell the CNA and the dayshift nurse that the night nurse told me I couldn't go to the hospital. But nobody did anything about it."

3. A record review of a facility reported incident for a neglect allegation, dated 9/20/21, showed, "On 9/20/21, it was reported by night shift that the dressing to resident, [#212], was dated 9/8/21 ... An allegation of neglect has been submitted ... the allegation of neglect is substantiated." According to the facility reported incident the facility found that a nurse falsified a record, documenting she had changed the dressing on 9/14/21, but she had not, and on 9/17/21 another nurse documented on the TAR that she changed the dressing because she thought that the wound care nurse had done the dressing change, but the dressing was not changed on 9/17/21 either.

During a telephone interview on 2/15/22 at 4:15 p.m., resident #212 stated, the wound was now healed but he remembered the incident. Resident #212 stated, "It was very painful. I had a hell of a time for it to heal. It was healed once then it got a blister under the dressing. It took it months for it to heal after they found it like that."

During an interview on 2/16/22 at 9:56 a.m., staff

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F 600	Continued From page 9	F 600		

member A stated it was her understanding that resident #212's wound was healed and then the nurse placed a dressing on it to protect it. When it was discovered that the protective dressing did not get changed on schedule, when they took the protective dressing off they found a new blister.

During an interview on 2/17/22 at 7:55 a.m., staff member A stated, "[Staff member HH] was terminated for falsifying documentation. She was educated on wound care. [Staff member HH] admitted that she falsified the document that she had changed the dressing but then didn't do it. That is all I remember about that."

A record review of resident #212's TAR, dated August 2021, showed, the protective dressing was changed on 8/4/21, 8/14/21 and 8/18/21, but it was not changed as ordered on 8/7/21 or 8/11/21. The bandage was left on and unchanged for 10 days.

A record review of resident #212's TAR, dated September 2021, showed, the protective dressing was changed on 9/3/21, 9/21/21 and 9/24/21, but was not changed as ordered on 9/7/21, 9/10/21, 9/14/21 or 9/17/21. The bandage was left on and unchanged for 14 days.

A record review of resident #212's skin/wound note, dated 7/28/21, showed, the left heal wound was healed and a protective dressing applied.

A record review of resident #212's skin/wound note, dated 9/20/21, showed, the "left heal dressing was not changed per physician order." There was no documentation to reflect any changes in the wound.

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F 600	Continued From page 10	F 600		

A record review of resident #212's antibiotic note, dated 9/22/21, showed, "Lt (left) heel wound, antibiotics x 5 days, dressing change. Date of infection 9/20/21." The wound required antibiotics at this point.

A record review of resident #212's Health Status Note, dated 9/23/21, showed, "wound to heel measures 0.5 x 3.5 x 0.1 serosanguinous drainage noted. This wound is due to resident receiving a shower with foam heel protector in place and was not changed per provider orders." There was no documentation to reflect the stage of the wound/ulcer.

4. Review of two facility reported incidents, dated 10/20/21 and 8/2/21, for verbal abuse toward resident #4 were investigated.

a. On 8/2/21 an allegation of verbal abuse was reported. A CNA overheard a nurse tell resident #4 "Maybe it would be better if you broke something, and we can get rid of you for a few weeks. You don't let me get my work done and I'm going to kill someone."

Review of resident #4's clinical record showed, at the time of the incident, the resident was moderately cognitively impaired with Alzheimer's Disease, and vascular dementia.

The facility did substantiate verbal abuse of resident #4. The nurse was suspended pending investigation. The nurse received a written disciplinary action, and was educated on customer service, and resident rights.

b. On 10/20/21 a CNA was overheard saying, "Don't you comprehend what I am saying

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F 600	Continued From page 11 (resident name). This was said in a harsh tone to Resident #4. Resident #4 was heard to respond with "I am a pain in the butt." The facility did substantiate verbal abuse of resident #4. The CNA was suspended pending investigation. The CNA was disciplined by the facility, and educated on customer service. A review of the facility's policy, Abuse and Neglect, dated May 2019, reflected: "Policy Statement: It is the policy of the facility to provide professional care and services in an environment that is free from ...neglect ... Neglect is the failure to provide necessary services and adequate (medical, personal or psychological) care ...failure to care for a person in a manner, which would avoid harm ...Staff may be aware or should have been aware of the service the resident requires, but fails to provide that service. ..."	F 600		
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	F 610		4/3/22

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BELLA TERRA OF BILLINGS	1807 24TH ST W BILLINGS, MT 59102

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F 610	Continued From page 12 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 failed to fully investigate alleged neglect for 2 (#s 5 and 212) out of 2 sampled residents. Findings include: 1. A record review of a facility reported incident, dated 9/19/21, showed resident #5 had not had her wound dressing changed for seven days. Resident #5's dressing was scheduled to be changed on Tuesdays and Fridays. Per the schedule, the dressing should have been changed on 9/10/21 and 9/14/21, but was not. The dressing did not get changed because resident #5 missed her wound care appointment as she was not ready to go when the driver arrived, and he had other residents to take to appointments. The nursing documentation did not prompt the nurse to do the dressing change since it otherwise would have been done at the appointment. (See F600 for details.) The nurse on duty failed to ensure measures were taken for the resident's wound treatment that was missed. A review of a facility document titled, "Verification of Investigation," dated 9/17/21, showed the form was not filled out completely. There were four areas to fill out, "provide a detailed description of event/allegation, assessment of resident/describe injury, resident interview summary, and immediate resident protection initiated." Only the first section, "Provide detailed description of	F 610	1. Resident #5 discharged on 2/20/2022. After the allegation the resident was seen wound clinic on 9/21/2021. Resident #212 discharged on 9/29/2021. After investigation nurse identified as falsifying documents was educated. 2. An audit of all residents receiving wound care consultation outside of facility was conducted and completed by 4/3/2022. The facility identified any missed appointments and current scheduled appointments for accuracy. An audit of all residents for last 30 days, was conducted to ensure completion and documentation of dressing changes was completed by 4/3/2022. Audit of all investigations for last 90 days to ensure completion of VOI form and review by DON and NHA by 4/3/2022. 3. NHA or designee will incorporate investigations and follow up into monthly QAPI meeting. Staff will be educated on abuse prevention and reporting and effective communication. Nursing staff will be educated on wound care orders, and transportation/appointment system. Regional Nurse Consultant completed education with DON and NHA regarding abuse investigations, checklist completion, VOI forms, and thorough investigation.	

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F 610	Continued From page 13 event/allegation," had anything written in it. The rest of the form was blank, other than a check mark in the box labeled YES for "immediate resident protection initiated," but the form failed to describe the action provided for the resident or other investigation details. 2. A record review of a facility reported incident, dated 9/20/21, showed, resident #212 had not had his protective dressing changed for 14 days causing a wound to develop. A record review of resident #212's TAR, dated September 2021, showed, the protective dressing was changed on 9/3/21, 9/21/21 and 9/24/21 but was not changed as ordered on 9/7/21, 9/10/21, 9/14/21 or 9/17/21. Showing the dressing did not get changed for 14 days. A record review of resident #212's Health Status Note, dated 9/23/21 showed, wound to heel measures 0.5 x 3.5 x 0.1 serosanguinous drainage noted. "This wound is due to resident receiving a shower with foam heel protector in place and was not changed per provider orders." (See F600 for details.) There was no "Verification of Investigation" form completed for this facility reported incident. During an interview on 2/16/22 at 9:49 a.m., staff member A stated, "When I do my investigations, we report first then we suspend staff if we need to. We get statements from those involved or from other residents as well. We look at documentation that is pertinent to that investigation, notify family and physician if needed. I'll do the investigation if there is abuse or neglect. [Staff member JJ] was the DON at the	F 610	Interdisciplinary team educated by DON/NHA on abuse investigation and reporting process. All education will be complete prior to 4/3/2022. 4. NHA or designee to audit all investigations for accuracy and thorough investigation each week until sustained compliance achieved. Audit of 25% of resident with wounds weekly for 4 weeks to ensure completion of dressing, wound care follow up, and documentation, then 25% of resident biweekly, and 25% of residents monthly until sustained compliance achieved. Audits of wound care appointments weekly for scheduling, attendance, and follow up for future appointments weekly for 12 weeks until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 610	Continued From page 14 time of the incidents, and she was handling those (resident #s 5 and 212's facility reported incident investigations). There is a form that we fill out that guides us through the process [staff member JJ] was not very faithful using those forms. So, the form should guide the process for the follow up. It is a tool that is created for (agency name) so you get to the resolution to the problem. But [staff member JJ] never finished them." Staff member A stated she looked at her QAPI notes for that time frame and there was nothing specific in them that showed the facility talked about the incidents or how to change the process to ensure investigations were completed.	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 failed to complete accurate assessments for 1 (13) of 4 sampled residents. This deficient practice had the potential to affect resident care and safety as it inaccurately depicted the residents' care needs. Findings include: During an interview on 2/15/22 at 1:17 p.m., resident #13 stated his pressure ulcer was healed sometime in January 2021. He was no longer going to the wound clinic. During an interview on 2/16/22 at 12:37 p.m., staff member EE said, "I spoke with the wound nurse, and the resident still has a small open wound, it is not fully healed. The wound clinic said	F 641	1. Skin assessment for Resident #13 completed and wound assessment with pictures completed by ADON/UM and wound nurse on or before 4/3/2022. 2.DON or designee will conduct an audit of all residents with wounds for accuracy of assessment of wounds will be completed by 4/3/2022. DON or designee will conduct an audit of skin assessments of patients with wounds completed for last 30 days for documentation, completion, and consistency with wound assessment by 4/3/2022. Audit of all care plans for residents with wounds for accuracy and completion by	4/3/22

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F 641	Continued From page 15 the wound is healed." A record review of resident #13's care plan,with an initiation date of 5/20/21, showed: " ... Weekly monitoring of wounds by wound nurse or designee -assessment -recommendations -measurement Date Initiated 7/23/21 ..." A review of the facility's "LGHC Skin Evaluation," completed by staff member GG, for resident #13 on 1/12/22 and 1/19/22, showed: " ...6. Pressure Ulcer site; 55) Right gluteal fold, Type; Pressure. ..." The area for measurement was left blank. Staff member GG did not document measurements for resident #13's pressure ulcer or recommendations for treatment as ordered by the physician. A review of the facility's "LGHC Skin Evaluation," done by staff member GG, for resident #13 on 2/4/22 and 2/12/22 showed: " ... 5. Resident has alteration in skin integrity: No ...." Staff member GG's documentation showed resident #13 no longer had an alteration of skin integrity. A review of the facility's "Wound Assessment Detail Report," dated 2/14/22, completed by staff member MM, showed a picture of a right gluteal	F 641	4/3/2022.. 3. Facility hired new wound nurse 3/8/2022. Facility developed an IDT meeting to cover wounds and other trends to report to QAPI occurring each week. Facility will report to wound clinic any changes in wounds on mutual patients. Nurses will be educated on wound program, wound assessments, skin assessments, wound clinic communication, and care plan by DON or designee. Nursing leadership educated on Wound Rounds program by DON or designee. All education completed by 4/3/2022. 4. DON or designee to audit wound assessments weekly for 12 weeks until sustained compliance on accuracy and completion. DON or designee to audit 25% or wound patients weekly skin assessments for accuracy and completion each week for 12 weeks until sustained compliance achieved. DON or designee to audit 25% or wound patients care plans for accuracy and completion each week for 12 weeks until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 641	Continued From page 16 upper posterior thigh wound with measurements of 0.3 X 0.4 X 0.1 (L x W x D). A review of staff member MM's progress note, dated 2/16/22 at 12:56 p.m., showed, "Upon wound assessment today writer measured a small opening of 0.2cm (L) x 0.2cm (W). Scar tissue noted around previous wound. No exudate. Will continue with current treatment."	F 641		
F 656 SS=E	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 rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		4/3/22

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F 656	Continued From page 17 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 failed to ensure a comprehensive care plan was developed and implemented, and that it included beneficial individualized focus areas, goals, and interventions for a resident with disruptive behaviors, for 1 (#4), of 4 sampled residents, and the resident's quality of life, and that of others was negatively affected, and the resident had a diagnosis of Alzheimer's/Dementia, and had been at the facility for an extended period of time. Findings include: During an interview on 2/16/22 at 9:11 a.m., NF2 said the facility did not provide adequate care for resident #4. NF2 said the facility had a recent care plan meeting for resident #4, and all disciplines were supposed to attend. NF2 said nursing should have been in attendance since resident #4's behaviors were all related to her medical problems. NF2 said she knew the facility did not want resident #4 in the facility due to all the behavior problems, but nursing would not document her behaviors consistently, good and bad, so the neuropsychologist could make a	F 656	1. Resident #4 care plan updated to include: individualized focus areas, goals, and interventions. 2.An audit of all residents with dementia care plans to ensure individualized focus areas, goals and interventions completed by DON or designee by 4/3/2022. 3.Social Services to review all the residents upon admission, with any change of conditions, and quarterly for dementia care plans. DON or designee will provide education to Social Services and MDS on completion of dementia care plans with individualized focus areas, goals, and interventions. All education completed by 4/3/2022. 4.NHA or designee to audit 5 dementia care plans for individualized focus areas, goals, interventions weekly for 4 weeks, then 3 care plans per week for 4 weeks, then 5 care plans per month for 2 months. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if	

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F 656	Continued From page 18	F 656		

determination on the approaches and medications for the resident to improve her quality of life. NF2 said when she was at the care plan meeting she had specifically requested the facility come up with some kind of behavior tracking so the information could be provided to the neuropsychologist.

During an interview on 2/16/22 at 11:28 a.m., staff member B said the facility staff were trying to track and document resident #4's behaviors to see what triggers her behaviors. Staff member B said the facility was working on education and plans were developed last week for resident #4, although the resident had admitted to the facility in early 2021.

During an interview on 2/16/22 at 2:12 p.m., staff member S said she would dump towels on the table for resident #4 to fold or she would call the activity staff to have someone take resident #4 to the activity room. Staff member S said there were some things she had shared with other staff to help intervene with resident #4's behaviors. Staff member S stated, "We've just recently started documenting on resident #4's behaviors. Resident #4 wanders, and she goes into other resident rooms frequently... but they get upset with her coming in their rooms. Especially at 2 or 3 o'clock in the morning." Staff member S said resident #4 would be up for 36 to 48 hours at a time and then crash for a day. She needed constant supervision.

During an interview on 2/16/22 at 3:26 p.m., staff member I said she was not the person responsible for writing dementia and behavior care plans for the residents. She said the nursing staff wrote the majority of the care plans for each

needed to sustain compliance.

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F 656	Continued From page 19	F 656		

resident.

Review of resident #4's Minimum Data Sets (MDS) from 2/25/21 to 2/2/22 showed the resident had wandered 4-6 days of the look back periods, behavior placed the resident at risk of getting into a potentially dangerous place and had a significant potential to affect other residents by intruding on their privacy.

A review of resident #4's Behavioral Symptoms CAA, with an ARD of 8/2/21, showed the resident's wandering behavior had worsened since the last assessment. The seriousness of the resident's behavioral symptoms indicated she was an immediate threat to herself.

A review of resident #4's current comprehensive care plan showed:

a. - "Focus: anxiety: I have had medication changes, I are [sic] to revisit on Dec 23rd. The medication change [sic] helped maybe a couple of days. since then I am very restless, my behavior os [sic] becoming demanding, I am wandering all over, I am bumping into others. I am asking excessively for diet coke. nursing to keep in touch with my providers - Date Initiated: 12/15/2021" The Focus failed to include contributing factors or outcomes based on the resident's diagnoses, that were measurable.

- "Goal: I will remain safe throughout my stay at [Facilty name] with the assistance of the staff." The goal failed to include a goal or information on how the resident may not negatively affect others, or how the resident's quality of life may be improved.

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F 656	Continued From page 20 - "Interventions: I need constant supervision when I am out of bed. I wander through the facility, and into others rooms. I ask for things nonstop, please monitor that I do not overeat, or drink too much at one time. toilet me often. Please have patience, as I just do not understand, I cannot sit still when IO [sic] am up. I do get very upset and can [sic] verbally abusive to others - Date Initiated: 12/15/2021." The interventions failed to correlate to outcomes, and did not address how staff were to protect other residents. b. - "Focus: MOOD/DEPRESSION- My PHQ severity score was 7/27. Depression causal factors include Diagnosis and history of depression; Reaction to multiple losses and increased dependency; Anger management and emotional distress. I presented with symptoms of depression during the PHQ interview including being so fidgety or restless that I have been moving around a lot; Feeling down, depressed, or hopeless; Feeling tired, or having little energy. Date Initiated: 02/08/2022"	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 §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 observation, interview, and record review, the facility failed to provide supervision to	F 689	1.Resident #56 care plan and orders updated to ensure staff are monitoring	4/3/22

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F 689	Continued From page 21 1 (#56) of 2 sampled residents, who were at risk for aspiration during meals; failed to prevent and remove a hazard for 1 (#12) of 15 sampled residents, and the electrical box located next to the resident's bed and recliner was pulled away from the wall and the wires could be observed; and the facility staff failed to secure chair railing in a resident's room, for 1 (#163) of 13 sampled residents. Findings include: 1. During an observation on 2/15/22 at 9:18 a.m., resident #56 was seated in her wheelchair, eating breakfast in her room, and coughing while she was eating her French toast. She was not being supervised by staff during the meal. During an observation on 2/16/22 at 8:50 a.m., resident #56 was seated in her wheelchair, in her room eating breakfast. She was not being supervised by staff during the meal. During an interview on 2/16/22 at 9:00 a.m., staff member J stated, if a resident needed assistance with meals the resident would be seated in the dining room. None of the residents that were eating in their room needed to be supervised while eating. Staff member J stated when the facility was not in outbreak (of Covid 19) it was a lot easier to make sure residents were being supervised when eating because staff could watch them all at once in the dining room. Staff member J stated resident #56 was not being supervised while eating, and she did not need supervision while eating. Review of resident #56's Speech Therapy Evaluation, dated 9/28/21, showed, "...New Goal ST will educate nursing staff on Pt [patient] compensatory strategies to reduce risk of	F 689	resident during eating activities by 4/3/2022. Resident #12 room□s electrical box repaired by 4/3/2022. Resident #163 room□s chair rail was secured to wall by 4/3/2022. 2.DON or designee will conduct an audit of all residents with altered diets to ensure they are assisted with meals or in areas of high observation, updated care plans to reflect current diet orders, and meal tickets reflect resident assistance by 4/3/2022. 3.DON or designee will provide education to staff on altered diets requiring observation for safety. DON or designee will provide education to staff on completion of maintenance work orders by 4/3/2022. 4.NHA or designee to audit 5 rooms for 12 weeks for safety of electrical boxes and chair rails for 12 weeks until sustained compliance achieved. DON or designee to complete 5 observations of resident with altered diets weekly to ensure care plan and diet ticket followed for 12 weeks until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 689	Continued From page 22	F 689		

aspiration for least restrictive diet. Target date: 10/21/21 ...ST educated CNA on Pt needing supervision for meals..."

Review of resident #56's care plan, with an initiation date of 4/26/21 showed, "...Serve meals in dining room with supervision..."

2. During an observation and interview on 2/14/22 at 3:56 p.m., resident #12 stated his electrical plug was falling off the wall. The electrical box located next to his bed and recliner was pulled away from the wall and the wires could be observed through the gap between the outlet and the wall.

During an interview on 2/15/22 at 2:40 p.m., staff member A stated, "There is no request for the electrical outlet coming off the wall (in resident #12's room), so we made one today."

A record review of a work order for the maintenance request, dated 2/15/22, showed a request to fix the electrical outlet after surveyors pointed out that the electrical box was coming away from the wall.

3. During an observation, interview, and record review, on 2/15/22 at 8:35 a.m., a surveyor observed a chair rail that was falling off of the wall in the resident's room. Resident #163 said the railing had been in that condition since she was admitted. Record review showed she was admitted on 1/26/22.

During an interview on 2/16/22 at 4:45 p.m., staff member A was not aware of the broken chair rail in resident #163's room. Staff member A was not able to find a maintenance work order request for

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F 689	Continued From page 23 repair of the chair rail. A review of facility document, "Work Order #3999," dated 2/16/22, showed staff member A placed a request for the chair rail repair for resident #163's room.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure adequate nutritional interventions were provided and monitored for 1 (#51) of 2 sampled residents. This deficient practice contributed to the resident having an unplanned severe weight loss of 23.4%	F 692	1.Resident #51 was reviewed by MD, RD, and IDT. Interventions updated in care plan. 2.RD or designee to audit all residents for weight loss and interventions. NHA or designee to interview residents on meal	4/3/22

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F 692	Continued From page 24 in under 3 months. Findings include: During an observation and interview, on 2/15/22 at 9:15 a.m., resident #51 received his breakfast which consisted of two eggs, one cup of yogurt, and a cup of orange juice. Resident #51 stated he did not get the 2 oz of ham he requested, and this was not the first time it had happened. The resident stated missing food items occurred about six out of ten meals. Review of the resident's food selection card on the resident's food tray showed the resident requested 2 oz of ham, in addition to two eggs, yogurt, and orange juice. During an interview on 2/16/22 at 8:29 a.m., staff member O stated the facility's system for nutrition monitoring was broken. Staff member O stated her vitamin recommendations, in addition to meat and other proteins, were needed to improve resident #51's wound healing. Staff member O stated the staff were not recording food intake every day. Staff member O stated the facility was supposed to have meetings to discuss residents who had severe weight loss, but the meetings did not happen. During an interview on 2/16/22 at 9:43 a.m., staff member N stated residents' food intake amounts were supposed to be documented every shift by the CNAs, and the CNAs were to let the nurses know if there was an amount eaten that was out of the normal range for the resident. Staff member N stated the food intake amounts were not completed if there were not enough staff, and documentation of food intake had been an issue for the past four months, which caused the lack of consistent food intake documentation for resident #51. Staff member N stated the facility's dietician	F 692	preferences being met for last 30 days. DON or designee to audit meal intake documentation for last 30 days. All audits complete by 4/3/2022. 3.Facility developed an IDT meeting to cover weight loss and other trends to report to QAPI occurring each week. DON or designee to provide education to nurse leadership on following up on RD recommendations. DON or designee will provide education to nursing staff on meal intake documentation, weight monitoring, and physician notification of weight issues, and check meal tickets for requested preferences. DON or designee will provide education to dietary staff on following meal preferences. All education completed by 4/3/2022. 4.DON or designee to audit 10 charts for weight loss, provider notification, meal intake charting and interventions weekly for 4 weeks, then 5 charts per week for 4 weeks, then 10 charts per month until sustained compliance Dietary manager or designee to audit meal trays for accuracy or requested items. 5 trays per day 5 days/ week for 4 weeks then 15 trays weekly for 8 weeks until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 692	Continued From page 25	F 692		

often asked why meal intakes were not charted because it was important for her to do her job and assess the resident's needs.

Review of resident #51's Care Plan, dated 10/24/21, reflected:

"Focus
[Resident #51] is at risk for alteration in nutritional status related to: ...wound areas. ...
Goal
No significant weight changes x 90 days.
Date Initiated: 10/24/2021 ..."

Review of resident #51's SBAR to a provider, dated 12/7/21, reflected, "Background: ...He has lost 5 lbs in the last couple weeks. ...Physician Orders: Will eval[uate]."

Review of resident #51's Nutrition Progress Note, dated 1/10/21, reflected:

"Recommend:

1. CMP.
2. Multivitamins with minerals one po daily with breakfast.
3. 500 mg of vitamin C one po TID with meals for skin healing.
4. 220 mg of zinc sulfate one po daily x 10 days for skin healing.
5. Weekly weights ...
MD and DON were notified of the nutrition recommendations in writing."

Review of resident #51's Nutrition Progress Note, dated 2/4/22, reflected:

"...Significant wt. [weight] loss x 3 mo [months]

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(23.4%/39.3# [pounds]). No labs are available to review ...Nutrition recommendations from 1/10/22 were not accepted. To prevent further wt. loss and to heal the skin, the resident needs the following:

1. Glucerna one po BID between meals.
2. Multivitamins with minerals one po daily with breakfast.
3. 500 mg of vitamin C one po TID with meals for skin healing.
4. 220 mg of zinc sulfate one po daily x 10 days for skin healing.
MD and the DON were notified of the above in writing."

Review of resident #51's Order Details, dated 2/11/22, reflected, "Glucerna one time a day for Wound Healing. Order Date: 2/11/2022."
This order was started seven days after the staff member O's recommendations, and was not at the frequency staff member O recommended to prevent further weight loss.

Review of resident #51's NUTRITION - Amount Eaten report, dated 12/1/21-2/15/22, reflected amounts of meals eaten were not documented for 45.3% of the days (34 out of 75 days).

A review of the facility's policy, Intake and Output and Fluid Restriction, created March 2021, reflected:

"To maintain a relative balance intake and output is essential for well-being and life. Accurately recording intake and output will assist in the assessment of this balance...
5. Record the total intake and output at the end of each shift. ..."

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F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement pain interventions in line with the resident's goals for 1 (#38) of 1 sampled resident. This deficient practice had the potential to affect the resident's ADLs and quality of life. Findings include: During an interview on 2/15/22 at 8:28 a.m., resident #38 stated his pain was not managed well, and he could not increase the use of his narcotics due to an interaction with his heart medications. Resident #38 stated he tried to distract himself from the pain, but it did not always work. During an observation and interview on 2/16/22 at 3:28 p.m., staff member Q stated she knew there were as needed (PRN) medications to manage resident #38's pain, and she thought there were distraction methods in his care plan. Staff member Q stated she did not know exactly what was on resident #38's care plan, as she had only worked with him for the past four days. Staff member Q looked at resident #38's care plan in the EMR, and scrolled through the interventions. Staff member Q stated she did not see any non-pharmacological interventions in resident #38's care plan.	F 697	1.Resident #38 pain assessment completed, and care plan updated for new nonpharmacological pain interventions by 4/3/2022. 2.DON or designee will conduct an audit of all residents to determine if non-pharmacological interventions are in place to assist with pain management and does the resident feel their pain is being well managed by 4/3/2022. 3.Facility developed a non-pharmacologic pain intervention toolkit. Facility developed an IDT meeting to cover pain management and other trends to report to QAPI occurring each week. DON or designee will provide education to nurses on pain management toolkit. All education completed by 4/3/2022. 4.DON or designee to audit for nonpharmacologic interventions in care plan of 10 charts per week for 4 weeks, then 5 charts per week for 4 weeks, then 10 charts X 1 month for non-pharmacologic interventions. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	4/3/22

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F 697	Continued From page 28	F 697		

Review of resident #38's Care Plan, reviewed 1/10/22, reflected:

"Focus
PAIN: I have chronic pain ...
Goal
I wish to be within a pain range that I can tolerate which is less than 5 through the next review.
Date Initiated: 12/07/2018
Target Date: 01/25/2022."

Review of resident #38's Pain Scale Graph, dated 12/1/21 - 2/16/22, reflected the resident's pain level at a five or above during 36.7% (44 of 120 opportunities) for pain assessments.

Review of resident #38's Quarterly MDS, with an ARD of 1/14/22, showed the resident had limited his day-to-day activities because of pain over the past five days preceding the MDS assessment.

Review of resident #38's January 2022 - February 2022 TAR, MAR, and Care Plan, reflected a lack of non-pharmacological pain interventions.

A review of the facility's policy, Care Planning, created September 2019, reflected:

"Policy:
Individual, resident-centered care planning will be ...maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life ...
2. Each resident has the right to ...continue their life-patterns as able ...
Procedure: ...
6. ...It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes. ...

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F 697	Continued From page 29 8. Care plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. ..." Resident 38's EHR documentation showed the resident's pain rating was above the scale noted on the care plan goal, on a consistent basis, and the resident's daily activities were hindered, but the facility failed to identify and implement alternate nonmedicinal interventions for the residents comfort and pain management needs.	F 697		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		4/3/22

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F 725	Continued From page 30 paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to shower residents timely, due to short staffing, to promote cleanliness and comfort for 5 (#s 9, 13, 24, 56, and 60) of 15 sampled residents; and failed to: provide enough staff to assist residents with their needs in a timely manner, chart daily food intake, assist with incontinence care as needed, assist with resident transfers safely, and order needed supplies for the resident, for 6 (#s 3, 4, 5, 27, 51, and 57) of 15 sampled residents. Findings include: During an interview on 2/16/22 at 9:30 a.m., staff member L stated she used to help with bathing residents in November and December of 2021, as well as January of 2022. Staff member L stated up until recently, the facility did not have a bath aide. Staff member L stated during that time, the facility was very short staffed, and bathing was not getting done if there were other CNA tasks. Staff member L stated there were quite a few days when residents were not getting bathed due to not having staff. 1. Review of resident #24's bathing documentation showed the resident did not receive a shower from: 11/4/21 - 11/22/21 (18 days) 12/16/21 - 12/30/21 (14 days) 2. Review of resident #56's bathing documentation showed the resident did not receive a shower from:	F 725	1.Resident #24 provided shower on 3/2/2022 per his preference of weekly showers. Resident #56 received shower 3/2/2022 per her preference of weekly showers. Resident # 3 interviewed regarding care and call lights. Resident #27 interviewed about call light. Resident #51 meal intake was reviewed for completion. Resident #5 and #57 skin check completed for skin issue related incontinence management. An audit of facility for supplies of gloves, foley supplies, insulin syringes for supplies. Resident #13 was provided shower on 3/3 and 3/7 per his preference. Resident #60 was interviewed for bathing preference and received shower 3/2/22, 3/4/22 and 3/7/22. Resident #9 was provided shower on 3/2. Resident #9 specialty wipes purchased on 2/24/2022 and 3/3/2022. Resident #9 interviewed regarding call lights. A review of current staffing levels to meet resident needs. 2.All residents are at risk. The facility has an active recruitment program and recently hired additional new staff members. The facility also employs nursing staff from staffing agencies as needed. The facility has a sister facility in the community to utilize shared staff as is needed and if available. DON or designee will interview all residents to obtain preferences for showers, new shower schedule completed and place on unit by	

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F 725	Continued From page 31 12/9/21 - 12/30/21 (21 days) During an interview on 2/16/22 at 8:43 a.m., staff member K stated if the shower sheet said 'non-applicable,' that meant the shower did not get done. Staff member K stated, "Back in December 2021 showers were not getting done, we were busy doing CNA duties, and we did not have a bath aide." 3. During an interview on 2/14/22 at 4:10 p.m., resident #3 stated he had to wait a while, sometimes hours, when he rang the bell for assistance because the facility was shorthanded with staff, especially on the weekends. 4. During an interview on 2/14/22 at 4:31 p.m., resident #27 stated the facility had light staffing on weekends, he had to wait a while when he needed assistance. Resident #27 stated it was dangerous that the facility was short staffed, because people could fall. 5. During an interview on 2/16/22 at 8:29 a.m., staff member O stated the nursing staff were not charting daily intakes and outputs of food and fluid because the facility was short staffed. Staff member O stated it was difficult to determine what resident #51 needed nutritionally when she could not tell what he had been eating. 6. During an interview on 2/16/22 at 9:43 a.m., staff member N stated it was typical for one nurse to oversee 20 residents, and there had been several nights where one nurse oversaw 47 residents. Staff member N stated one of those nights was on 2/14/22, where she worked midnight to 6:00 a.m., otherwise the nurse that	F 725	4/3/2022. 3.A daily staffing meeting with NHA, DON, staffing coordinator and RNC, RDO and VP of Clinical as able will be instituted to ensure staffing levels and acuity reviewed. The call light system repairs in process and projected to be completed on or before 4/3/2022. DON or designee will conduct education to Central supply coordinator on ordering system and supply PAR levels on or before 4/3/2022. DON or designee will educate staff on customer service. DON or designee will educate nursing staff on shower schedules, completion of meal charting, 2 hours chart checks, answering of call lights, and mechanical lifts transfers. All education completed on or before 4/3/2022. 4.DON or designee to audit showers for completion 5 days weekly for 12 weeks until sustained compliance achieved. DON or designee to audit meal intake documentation 5 days weekly for 12 weeks until sustained compliance achieved. DON or designee to interview 10 residents per week on call light response, assistance with ADL cares, transfers, and shower preferences weekly for 12 weeks until sustained compliance achieved. DON or designee to conduct 10 call light observations for response time per week for 12 weeks until sustained compliance achieved. DON or designee to conduct 10 random observations per week of mechanical lift transfer and ADL cares for 4 weeks, then 5 observations per week for 4 weeks, then 10 observations monthly for 2 months until	

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F 725	Continued From page 32 night would have had 47 residents to oversee. Staff member N stated weekend staffing had been short since November (2021). Staff member N stated because of the short staffing, the staff would perform a one person assist when a resident required a two person assist with a lift, and this was dangerous because a resident could fall. Staff member N stated she had told her managers about the staffing concern, but it seemed like no one had done anything to remedy it, and she did not see anyone from management help on the floor. Staff member N stated that staff were leaving, and the agency staff hardly showed up for work. Staff member N stated resident brief changes were not getting done due to short staffing, and because of this, resident #5 and 57's incontinence briefs were not changed during the night shift on 2/15/22. During an interview on 2/16/22 at 9:59 a.m., staff member N stated that on 2/12/22, the unit ran out of catheter bags, gloves, and insulin syringes. Staff member N stated that staff member P oversaw supply ordering, but was doing three other jobs: reception, staff coordinator, and scheduling, because the facility was short staffed, and she had been unable to keep up with the supply needs of the facility. Staff member N also stated because of short staffing, the residents received breakfast late, at 8:30 a.m., on 2/12/22. 7. During an interview on 2/15/22 at 1:17 p.m., resident #13 said, "In January, I didn't have a shower for 2 weeks. They didn't have staffing to provide a shower." A record review of a facility document for bathing tasks, dated 1/17/22 through 1/26/22, showed resident #13 peferred to shower twice weekly.	F 725	sustained compliance achieved. DON or designee to audit supply weekly to ensure insulin syringes, foleys, and gloves are available. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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Resident #13 received a shower on 1/17/22 and 1/26/22, nine days apart. A record of resident #13's bathing task documentation for 1/1/22 through 1/16/22 was not provided prior to the end of the survey.

8. During an interview on 2/15/22 at 8:15 a.m., resident #60 stated, night shift was often short staff, and she had gone seven to nine days without a shower. Resident #60 said she had talked and sent notes to staff member A about showering.

A record review of a facility document for bathing tasks, dated 1/17/22 through 1/31/22, reflected, resident #60 received a shower on 1/17/22 and 1/30/22, with 18 days between showers. A record of resident #60's bathing task documentation for 1/1/22 through 1/16/22 was not provided prior to the end of the survey.

9. During an interview on 2/15/22 at 10:45 a.m., resident #9 stated, last month she went without showers. Resident #9 said she needed to have her pannus cleaned daily and the facility had run out of wipes. Resident #9 said, when that happened, she could smell herself and hated it. Resident #9 also stated, staffing was difficult, staff called in or did not show up, the facility would have to find someone emergently. The CNA would come to the call light to assist and tell resident #9 that they would be back after assisting others or finding help and turned the call light off. The CNA would forget or get busy, and not return, so resident #9 had to turn her call light back on.

A record review of facility document for bathing tasks, dated 1/17/22 through 1/31/22, reflected,

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F 725	Continued From page 34	F 725		

resident #9 preferred bathing two times a week. Resident #9 received only one shower between 1/17/22 and 1/31/22.

During an interview on 2/16/22 at 7:43 a.m., staff member S stated, "When I need help with a Hoyer lift, I need to find someone to help, and I can't always find someone. I have let scheduling know we need help due to resident #4. I don't have time to take proper care of the residents." Staff member S said she spent five hours one day just attending to resident #4, to keep her from running into walls and to keep her safe. Staff member S said the unit had ten residents, with five residents requiring a two person assist. Currently the Copper Crest West Unit was staffed with one CNA for the ten residents, resident #4 resides on this unit.

During an interview on 2/16/22 at 11:28 a.m., staff member B stated the Copper Crest West and Rim View West were considered all one unit. The facility staffing standard was four CNAs and two bath aides. When staff called off, the facility attempted to get the shift covered with prn and on call staff. One staff member carried an on-call phone. Sometimes, it would require a manager to cover the shift.

A record review of the "Facility Assessment," dated December 2021- November 2022, reflected:

" ... Our staffing plan is exclusively based on keeping the continued needs of our resident in focus and providing adequate staffing levels at all times so that their basic, individualized needs are met. ...
Nursing services ... Staffing levels appointed

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F 725	Continued From page 35 given the unique needs of the residents and the units they reside on. ..."	F 725		
F 741 SS=E	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure sufficient and competent staff were available for 1 (#4), based	F 741	1.Facility unable to identify resident #16 as they are not included on facility sample list. Resident #9 care plan evaluated for	4/3/22

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F 741	Continued From page 36 on the residents comprehensive assessments, for a resident with dementia/Alzheimers, and the resident's behavior hindered her daily life and that of others, to include 2 (#9 and 16) of 4 sampled residents. Staff working with resident #4 lacked the necessary training on the resident's individual needs, and ways to assist or effectively intervene with resident #4's behaviors/activity. Findings include: Resident #4 was admitted to the facility with Alzheimer's and vascular dementia with behavioral disturbance and conduct disorder. The resident had been at the facility since February 2021. During an interview on 2/14/22 at 3:53 p.m., resident #16 voiced concerns about resident #4's behaviors. Resident #16 said the nursing staff spent a lot of time chasing resident #4 around the facility, and taking care of resident #4 was at the expense of caring for the rest of the residents in the facility. Resident #16 said resident #4 wandered all around, and would yell for help. The resident went into everyone's room at all times of the day and night, and resident #16 said that caused a huge lack of privacy. Resident #16 said she had filed a grievance report with the facility due to resident #4's wandering, and entering resident rooms. Resident #16 said there had been a number of times the medication pass had been interrupted because the nurse and the CNA were trying to "corral" resident #4. Resident #16 said resident #4 also wandered the unit and yelled all night, and no one else got any sleep. Resident #16 said the unit did not have enough staff to take care of resident #4, and the rest of the residents on the unit.	F 741	ADL and care needs. Resident #4 care plan updated to include: individualized focus areas, goals, and interventions on or before 4/3/2022. 2.All residents with dementia have the potential to be affected. An audit of all residents with dementia conducted with a review of care plan completed by DON or designee on or before 4/3/2022. 3. DON or designee will conduct a review of dementia programing in facility, outreach to organizations for assistance, and consultation to certified dementia practitioner for facility dementia programing. DON or designee will conduct education on dementia care to nursing staff by DON. All education completed on or before 4/3/2022. 4.DON or designee to observe 5 residents with dementia for individualized interventions implemented by staff 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 10 times per month for 2 months until sustained compliance achieved. DON or designee to interview 3 staff per week for competency and tools to effectively assist with management of dementia care for 12 weeks until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 741	Continued From page 37	F 741		

During an observation on 2/15/22 at 9:37 a.m., resident #4 was going down the hall calling "hello." The resident rolled into a wall calling out "Hello, I am here. I am coming in. Hello, hello, hello." A staff member came out of room 235, saw resident #4 and wheeled her back to her room.

During an interview on 2/15/22 at 10:45 a.m., resident #9 said staff spent a lot of time chasing resident #4, and trying to keep her out of other resident rooms. Resident #9 said resident #4 always entered her room at night when she was sleeping and woke her up. Resident #9 said she did not sleep well.

During an interview on 2/16/22 at 9:11 a.m., NF2 said the facility did not provide adequate care for resident #4, and "I know she wanders and goes into other resident rooms, and they get upset. NF2 said the facility had a recent care plan meeting for resident #4, and all disciplines were supposed to attend. NF2 said, "It was me, the activity director, social services, and the ombudsman." NF2 said nursing should have been in attendance since resident #4's behaviors were all related to her medical problems.

During an interview on 2/16/22 at 11:28 a.m., staff member B said if resident #4 was having a difficult day the facility would have a plan to provide someone to come in to help if she was overwhelming the staff. Although the facility stated this plan was in place, the resident's behaviors continued to negatively affect others.

During an interview on 2/16/22 at 2:12 p.m., staff member S said she had not received any behavioral or dementia training for resident #4.

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F 741	Continued From page 38	F 741		

Resident #4 wanders, and she goes into other resident rooms frequently. The other residents understand she can't see, and she has dementia, but they get upset with her coming in their rooms. Especially at 2 or 3 o'clock in the morning." She said the other residents on Copper Crest West would get upset because when resident #4 is on the go, she needed constant supervision, and the other residents did not get their needs addressed.

During an interview on 2/16/22 at 2:18 p.m., staff member FF said she had not received any education or training on minimizing or limiting resident #4's behaviors.

During an interview on 2/16/22 at 3:26 p.m., staff member I said she had not provided actual training to facility staff in regards to resident #4's diagnoses and behaviors.

Review of the facility's "Grievance and Satisfaction Form," dated 2/7/22, showed resident #16 had filed a grievance with the facility regarding resident #4's behaviors. Resident #16 felt it necessary to file a grievance related to the concerns and #4 intruding on her personal space. Resident #4's staff supervision was not adequate to meet either resident #4's or #16's needs.

Review of resident #4's nursing progress notes showed:

- 1/27/22 at 9:47 p.m.: ".. Goes into other resident's [sic] rooms... runs into staff and walls with wheelchair, constant yelling and screaming, and wanders the halls... No nonpharmacological or pharmacological interventions were documented at that time.

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F 741	Continued From page 39	F 741		

- 2/4/22 at 12:27 a.m.: "... Enters other resident's [sic] rooms... constantly yelling. Is very difficult to redirect... " No nonpharmacological or pharmacological interventions were documented at that time.

- 2/14/22 at 6:14 a.m.: "Late note for 2/13/22, resident slept on and off throughout the morning. Up late afternoon with calling out help me, help me. Resident had snacks and a diet soda. She wandered around trying to get into other resident's room. No nonpharmacological or pharmacological interventions were documented.

- 2/14/22 at 7:19 p.m.: "Resident continuously wondering [sic] while she is awake. wanders into others rooms. constantly wanting someone by her side to talk to."
- 2/13/22 evening staff documented the resident was wandering and yelling all night.
- 2/14/22 day staff documented the resident was voicing repetitive statements, and wandering.

Review of resident #4's Minimum Data Sets (MDS) from 2/25/21 to 2/2/22 showed the following:

- Significant MDS, with an ARD of 8/2/21, showed resident #4 had wandered 4-6 days of the seven day look back period. The impact of the wandering behavior showed the behavior had a significant potential to affect other residents by intruding on their privacy.

A review of resident #4's care plan showed:

- "Interventions: I need constant supervision when I am out of bed. I wander through the facility, and in to others rooms... I do get very upset and can

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F 741	Continued From page 40 [sic] verbally abusive to others Date Initiated: 12/15/2021"	F 741		
F 744 SS=G	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure necessary services were provided for a resident who displayed behavioral outbursts, wandering, intruding on others, and calling out, and the resident had a diagnosis of Alzheimer's/dementia, for 1 (#4); and resident #4's behavior affected other residents, to include 2 (#s 9 and 16) of 4 sampled residents. The facility also failed to use available medication to treat and attempt to decrease resident #4's agitation/behavior if there was no improvement shown after an antipsychotic medication was started. Resident #4's care plan lacked non-pharmacological interventions for the resident's behavioral needs. These failures continued over an extended period of time, without timely action taken to address the concerns, which affected the residents quality of life on a regular basis. Findings include: Resident #4 was admitted to the facility on 2/19/21 with diagnoses including: mixed Alzheimer's and vascular dementia with behavioral disturbance, Anton's syndrome, anxiety, major depression, and conduct disorder.	F 744	1.Resident #4 behavior tracking implemented on 2/11/2022 per recommendation from care conference. Resident #4 care plan was updated for non-pharmacological interventions for behaviors of wandering, yelling out, sleep monitoring, and disruptive behaviors. 2.All residents with dementia are at risk. An audit of all residents with dementia care plans to ensure non-pharmacologic interventions by 4/3/2022. 3.Facility will engage with a certified dementia practitioner for education and development of dementia programing on or before 4/3/2022. Staff will be educated on dementia and behavior management and staff to be educated on nonpharmacologic interventions on or before 4/3/2022. 4.NHA or designee will audit residents with dementia care plans for accuracy and completion 5 per week for 4 weeks, 3 per week for 4 weeks, then 5 per month for 2 months until sustained compliance achieved. DON or designee to observe 5 residents with dementia for individualized	4/3/22

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F 744	Continued From page 41 During an interview on 2/14/22 at 3:53 p.m., Resident #16 said resident #4 wandered all around and would yell for help. The resident went into everyone's room at all times of the day and night, and resident #16 said that caused a huge lack of privacy. Resident #16 said she had filed a grievance report with the facility due to resident #4's wandering, and entering resident rooms. During an observation on 2/15/22 at 9:37 a.m., resident #4 was going down the hall calling "hello." The resident rolled into a wall calling out "Hello, I am here. I am coming in. Hello, hello, hello." A staff member came out of room 235, saw resident #4 and wheeled her back to her room. During an interview on 2/15/22 at 10:45 a.m., resident #9 said resident #4 always entered her room at night when she was sleeping and woke her up. Resident #9 said she did not sleep well. During an interview on 2/16/22 at 9:11 a.m., NF2 said the facility did not provide adequate care for resident #4. NF2 said the resident had a diagnosis of Anton's syndrome - which was cortical blindness. She said resident #4 would confabulate, which was part of the syndrome, and convince people she could see. The expectations of the facility staff were for resident #4 to be able to do the same things as a sighted person. NF2 said resident #4 had seen a neuropsychologist several times in the last couple of months. NF2 said the neuropsychologist told her that resident #4's short-term memory was to the point where it reset every 3-5 minutes. [Resident #4] can be combative, but if you let her know you are there and will be touching her she is calm. If you just walk up to her and she doesn't know you are	F 744	interventions implemented by staff 5 times per week for 4 weeks, then 3 times per week for 4 weeks, then 10 times per month for 2 months until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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there, it scares her and she will become combative." NF2 said given the limitations imposed by resident #4's short term memory problems, she felt resident #4 viewed the facility as her home, and therefore could not understand why she could not go into any room she chose, and when in those rooms perhaps she saw the other residents as intruders. NF2 said the facility had a recent care plan meeting for resident #4, and all disciplines were supposed to attend. NF2 said, "It was me, the activity director, social services, and the ombudsman." NF2 said nursing should have been in attendance since resident #4's behaviors were all related to her medical problems. NF2 said she knew the facility did not want resident #4 in the facility due to all the behavior problems, but nursing would not document her behaviors consistently, good and bad, so the neuropsychologist could make a determination on the approaches and medications for the resident to improve her quality of life. NF2 said when she was at the care plan meeting she had specifically requested the facility come up with some kind of behavior tracking so the information could be provided to the neuropsychologist.

During an interview on 2/16/22 at 11:28 a.m., staff member B said the facility staff were trying to track and document resident #4's behaviors to see what triggers her behaviors. She said staff member I was involved with this. Staff member B said the facility was working on education and plans were developed last week for resident #4, although the resident had admitted to the facility in early 2021.

Review of a social service progress note, dated 2/11/22 at 2:48 p.m., showed: "A quarterly care

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conference was held today, 2/11/22 @ 10:30 a.m. The following were present: daughter, Ombudsman, Activities, and Social Services. SS went through information that was on Multidisciplinary Care Conference UDA. Daughter had some concerns. SS spoke to Administrator and DON about those concerns. DON put behavior charting in MAR so that the nurses would have to progress note each shift and mark it off that it was done. Code status reviewed. ...Appointment scheduled next Thursday, 2/17/22 @ 1pm with [neuropsychologist's name]. SS will send updated progress notes early next week. SS will send a referral to [Hospital name] in Helena. SS will continue to follow resident."

During an interview on 2/16/22 at 2:12 p.m., staff member S said she had not received any behavioral or dementia training for resident #4. The staff member said the social worker was going to provide training specific to resident #4's behavioral concerns, but it never happened. She said she would dump towels on the table for resident #4 to fold or she would call the activity staff to have someone take resident #4 to the activity room. Staff member S said there were some things she had shared with other staff to help intervene with resident #4's behaviors. Staff member S stated, "We've just recently started documenting on resident #4's behaviors. Resident #4 wanders, and she goes into other resident rooms frequently. The other residents understand she can't see, and she has dementia, but they get upset with her coming in their rooms. Especially at 2 or 3 o'clock in the morning." Staff member S said resident #4 would be up for 36 to 48 hours at a time and then crash for a day. She said the other residents on Copper Crest West would get upset because when resident #4 is on

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the go, she needed constant supervision, and the other residents did not get their needs addressed. Staff member S stated, "On this unit it's me... and the nurse to provide care for the residents."

During an interview on 2/16/22 at 2:18 p.m., staff member FF said she had not received any education or training on minimizing or limiting resident #4's behaviors.

Review of resident #4's neuropsychologist's report, dated 12/28/2021, showed, "Plan: ... - start risperidone 0.5mg BID, after 2 days if no improvement in behavior increase to 1mg BID..."

During an interview on 2/16/22 at 3:16 p.m., staff member B said she was not aware the neuropsychologist had written, "If no improvement in behaviors increase risperdone to 1 mg BID."

During an interview on 2/16/22 at 3:26 p.m., staff member I said she had not provided actual training to facility staff in regards to resident #4's diagnoses and behaviors. Staff member I said the DON told her last week she needed to do a "huddle" with the nursing staff for resident #4's diagnosis and behavior management. Staff member I said she was not the person responsible for writing dementia and behavior care plans for the residents. She said the nursing staff wrote the majority of the care plans for each resident.

Review of the facility's "Grievance and Satisfaction Form," dated 2/7/22, showed resident #16 had filed a grievance with the facility regarding resident #4's behaviors. Resident #16 wrote, "[resident name] was being loud and

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disruptive all night 2/5 claiming there was fire. Approx. 5am 2/6 [resident name] opened my door and walked in while I was partially naked during check & change. [Staff name] removed her but my privacy was violated & I wanted it on the rec." The facility's resolution for this grievance showed, "1. Resident evaluated by physician. 2. Stop sign placed on door." The facility's investigation for this grievance showed, "Residents upset c [with] other resident A [resident #4]. Resident A wanders & is blind. Resident A wandered into resident B room. Attempted re-direction unsucessful [sic]."

Review of resident #4's nursing progress notes showed:

- 1/27/22 at 9:47 p.m.: "Continues to have adverse behaviors. Goes into other resident's [sic] rooms, continuously asks to go to the restroom when she has just been, asks to lay down and gets right back up, runs into staff and walls with wheelchair, constant yelling and screaming, and wanders the halls... Has not slept thus far this shift. will continue to monitor." No nonpharmacological or pharmacological interventions were documented at that time.

- 2/4/22 at 12:27 a.m.: "Resident continues with behaviors. Enters other resident's [sic] rooms, runs into staff with wheelchair, goes to bed and gets right back up, runs into walls ad [sic] equipment, and constantly yelling. Is very difficult to redirect. Denies any pain at this time. Will continue [sic] to monitor." No nonpharmacological or pharmacological interventions were documented at that time.

- 2/9/22 at 10:26 p.m.: "Resident was running chest into the table in the dinning [sic] room on

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the west unit. Non-Pharmacological Interventions: Redirected, resident stated that she did not know she was doing it."

- 2/14/22 at 6:14 a.m.: "Late note for 2/13/22, resident slept on and off throughout the morning. Up late afternoon with calling out help me, help me. The resident had snacks and a diet soda. She wandered around trying to get into other residents' rooms. Had to one on one to keep her from bothering others. No nonpharmacological or pharmacological interventions were documented.

- 2/14/22 at 7:19 p.m.: "Resident continuously wondering [sic] while she is awake. wanders into other rooms. constantly wanting someone by her side to talk to."

A review of resident #4's monitoring record, dated 2/1/2022 to 2/28/2022 with a start date of 2/11/2022, showed, "Nurse must enter progress note every shift regarding residents [sic] behavior. Identify wandering into rooms, yelling out, repetitive statements, or others, every shift for Behavior"

- 2/11/22 evening staff documented the resident was voicing repetitive statements and wandering.
- 2/12/22 day staff documented the resident was voicing repetitive statements and wandering.
- 2/12/22 evening staff failed to document the resident was exhibiting any behaviors.
- 2/13/22 day staff documented the resident was wandering.
- 2/13/22 evening staff documented the resident was voicing repetitive statements, wandering, and yelling all night.
- 2/14/22 day staff documented the resident was voicing repetitive statements, and wandering.

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- 2/14/22 evening staff documented NA for repetitive statements, wandering, and yelling.

Review of resident #4's Minimum Data Sets (MDS) from 2/25/21 to 2/2/22 showed the following:

- Significant Change MDS, with an ARD of 8/2/21, showed resident #4 had wandered 4-6 days of the seven-day look-back period. The impact of the wandering behavior showed the behavior placed the resident at risk of getting into a potentially dangerous place and had a significant potential to affect other residents by intruding on their privacy.

- The Quarterly MDS, with an ARD of 11/2/21, showed resident #4 had wandered daily during the 7-day look-back period. The impact of the wandering behavior to the resident and other residents was not completed.

- The Quarterly MDS, with an ARD of 2/2/22, showed resident #4 had a severe cognitive deficit. The resident had wandered 4-6 days of the 7-day look-back period. The impact of the wandering behavior of the resident and other residents was not completed.

A review of resident #4's Behavioral Symptoms CAA, with an ARD of 8/2/21, showed the resident was wandering 4-6 days of a 7-day look-back period, and the resident's wandering behavior had worsened since the last assessment. The seriousness of the resident's behavioral symptoms indicated she was an immediate threat to herself.

A review of resident #4's current care plan

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showed:

a. - "Focus: anxiety: I have had medication changes, I are [sic] to revisit on Dec 23rd. The medication change [sic] helped maybe a couple of days. since then I am very restless, my behavior os [sic] becoming demanding, I am wandering all over, I am bumping into others. I am asking excessively for diet coke. nursing to keep in touch with my providers
Date Initiated: 12/15/2021"

- "Goal: I will remain safe throughout my stay at [Facilty name] with the assistance of the staff.
Date Initiated: 12/15/2021
Target Date: 03/31/2022"

- "Interventions: I need constant supervision when I am out of bed. I wander through the facility, and into others rooms. I ask for things nonstop, please monitor that I do not overeat, or drink too much at one time. toilet me often. Please have patience, as I just do not understand, I cannot sit still when IO [sic] am up. I do get very upset and can [sic] verbally abusive to others
Date Initiated: 12/15/2021"

b. - "Focus: MOOD/DEPRESSION- My PHQ severity score was 7/27. Depression causal factors include Diagnosis and history of depression; Reaction to multiple losses and increased dependency; Anger management and emotional distress. I presented with symptoms of depression during the PHQ interview including being so fidgety or restless that I have been moving around a lot; Feeling down, depressed, or hopeless; Feeling tired, or having little energy.
Date Initiated: 02/08/2022"

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F 744	Continued From page 49 - "Goal: I will engage in mental health treatment and work on improving mood state and outlook, through my next review date. Date Initiated: 02/08/2022 Target Date: 03/31/2022" - "Interventions: I will talk to staff that I feel comfortable with about ideas to moderate and reduce my mood distress symptoms such as: sharing thoughts and feelings that have contributed to depression. Staff will notify my Provider and Social Services if they see an increase in any signs and/or symptoms of depression. Date Initiated: 02/08/2022" During an interview on 2/17/22 at 8:03 a.m., staff member D said she did not write care plans. She said the unit managers did that. Staff member D said staff member C wrote the care plans for the unit the resident resided on. During observation and attempted interview on 2/17/22 at 8:06 a.m., staff member C was working at a medication cart. Staff member C verified she would have written the majority of resident #4's care plan. Staff member C was not available for further interviews prior to the survey team exiting the facility.	F 744		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		4/3/22

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F 758	Continued From page 50 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic 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 psychotropic 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 psychotropic 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 psychotropic 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 anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 51 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure an as needed (PRN) psychotropic medication was reviewed after 14 days, and the facility failed to ensure the medication was discontinued unless a rationale for continuing the medication was documented by the physician, for 1 (#4) of 5 sampled residents. Findings include: Review of resident #4's Order Summary Report, active orders as of 2/15/2022, showed the resident was prescribed, on 12/28/2021, risperdone 0.5 mg by mouth every 6 hours as needed for agitation... Review of medication administration records for January 2022 and February 2022 showed resident #4 had a PRN risperdone order effective 12/28/2021. The resident had received doses of the PRN risperdone on 1/10/22, 1/16/22, 1/24/22, 2/4/22, 2/7/22, and 2/11/22, with a total use of six times in 45 days. Review of a pharmacy consultation report, with a recommendation date of 1/19/22, showed the pharmacist recommended the PRN risperdone be discontinued. The consultation report also contained instructions to the physician for continued use of an as needed psychotropic to include: "A new order should not be written without the prescriber directly examining the resident and assessing the resident's condition and progress to determine if the PRN antipsychotic is still needed." The physician's response to the pharmacist's consultation report	F 758	1.Resident #4 PRN medication discontinued on 2/17/2022. 2.An audit of all psychotropic medications for PRN use and stop date with results reported to physician on or before 4/3/2022. 3.Nursing leadership to review all orders in morning clinical meeting to review psychotropic medication and required stop dates. Educate nurses on requesting stop dates for prn psychotropic medications. All education completed by 4/3/2022. 4.DON or designee to audit new psychotropic orders 5 times per week for 4 weeks, then 3 times per week for 4 weeks, and weekly for 2 months. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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was marked: "I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: Continue for behaviors if needed." The physician signed off his rationale on 1/26/22.

Review of physician progress notes dated 1/27/22 and 2/12/22 failed to show the practitioner reassessed resident #4 for the PRN risperdone on either date.

During an interview on 2/16/22 at 10:33 a.m., a nurse said staff member Z was the physician's assistant who took care of the residents at the facility. The nurse said staff member AA only did the certification visits. The nurse said NF1 was also responsible for controlling medications for resident #4.

Review of resident #4's psychiatric progress notes dated 12/7/21 and 12/28/21, did not show NF1 had prescribed the PRN risperdone for the resident.

During an interview on 2/16/22 at 10:49 a.m., staff member B said she had identified this as a problem, "nursing not getting a 14 day time limit for the PRN psychotropic medications from the prescribers." Staff member B said nursing education on this problem had been started last Thursday 2/10/22.

Review of facility policy "Psychotropic Medications," revised date 5/18/2021, showed:

- "6. As needed (PRN) psychotropic medications for psychological symptoms will not be prescribed for great than 14 days. After 14 days, the physician must evaluate the resident for the

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F 758	Continued From page 53 continued need for the prn psychotropic medication and can rewrite the order..."	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure nursing staff input the correct medication orders for 2 (#s 38 and 262) of 2 sampled residents. These deficient practices had the potential to increase the potential of a blood clot and stroke for resident #262, and delay healing for resident #38. Findings include: 1. During an interview on 2/16/22 at 10:30 a.m., staff member M stated there was a different process for entering Coumadin orders, compared to other orders, and the Coumadin orders were to be checked by two nurses. One nurse was to input the orders into the EMR, and those orders were to be checked by a second nurse right after they were entered. During an interview on 2/16/22 at 10:33 a.m., staff member B stated the expectation for nursing staff, when entering an order for Coumadin, was to enter the order with an end date, the correct dose from the order, and to enter the order on the facility's Coumadin tracking sheet. Staff member B stated the facility had two nurses assess the order, and there were clinic meetings in the mornings where orders were also reviewed. During an interview on 2/16/22 at 1:37 p.m., staff	F 760	1.An audit of resident #38 medical records to verify physician orders. Resident #262 discharged on 8/15/2021. 2.DON or designee will conduct an audit of all residents with coumadin for order entry accuracy on or before 4/3/2022. DON or designee will conduct audit of all admissions and re-admissions for last 30 days for accuracy of order entry on or before 4/3/2022. 3.All nurses to verify with second nurse coumadin orders for entry. All nurses to verify admission orders with two nurses. DON or designee will conduct education to nurses on coumadin order entry and admission order entry. Competencies for al licensed nurses on order entry. All education and competencies on or before 4/3/2022. 4.DON or designee to audit coumadin orders for accuracy, flow sheet, and checking by two nurses 5 times per week for 4 weeks, 3 times per week for 4 weeks, and weekly for 4 weeks until sustained compliance achieved. DON or designee to audit all new admission/re-admissions for accuracy of orders 5 times weekly for 12 weeks until	4/3/22

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F 760	Continued From page 54 member B stated the facility was working on creating a policy and system for double checking all medication orders that were entered in the facility's EMR. On 2/16/22 at 2:12 p.m., a request was given to staff member A for the facility's Coumadin order entering policy. During an interview on 2/16/22 at 4:45 p.m., staff member A stated the facility did not have a policy for entering coumadin orders into the EMR. A review of the facility's investigation notes for a facility reported incident, regarding resident #262, submitted 8/13/21, reflected, "On 8/12/21 the facility was notified of a significant medication error regarding Coumadin that resulted a critical PT/INR on resident, [#262]. The resident's Coumadin order ...was Coumadin 4 mg to be given on 8/7 and 8/8. The nurse working the floor [staff member LL] had entered to [sic] Coumadin order into the EMAR but put the discontinue date as 8/7 resulting in a missed dose on 8/8/21. ..." Review of resident #262's Order Details, dated 8/6/21, reflected, "Give 4 mg [Coumadin] by mouth at bedtime every Tue, Sat, Sun for Long term anticoagulant use until 08/07/2021 23:59." The date was circled, and written next to it was, "Should have been 8/8/21." Review of the facility's Education/Training sheet, Subject: Coumadin Orders/Process, dated 7/21/21, reflected staff member LL and other staff members received training on the subject, prior to the incident with resident #262, on 8/6/21. A review of the facility's Coumadin checklist	F 760	sustained compliance achieved. Reported to QAPI on 4/1/2022.	

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reflected there was two spaces for two nurses to verify Coumadin orders, with signatures.

Review of resident #262's Coumadin checklist reflected one signature by staff member LL, with no other space for a second nurse to verify and sign.

2. Review of resident #38's After Visit Summary, dated 1/7/22, reflected:

"Patient Medication List
Cephalexin 500mg capsule ...
Dose: 1,000 mg ...
Take 2 capsules (1,000 mg total) by mouth three times a day for 7 days Indications: Skin and Soft Tissue Infection
Received morning dose prior to discharge 01/07/2022. ..."

Review of resident #38's Order Note, dated 1/13/22 at 12:00 p.m., reflected, "Data: Resident was d/c on 1/7/22 and ordered Cephalexin 1000 mg three times daily for seven days. Comments: However, he was only receiving 500 mg three times daily. ..."

Review of resident #38's MAR, dated 1/1/22 - 1/31/22, reflected, "Cephalexin Tablet 500 MG Give 500 mg by mouth three times a day for infection until 01/14/2022 23:59 -Start Date- 01/08/2022 0600." The MAR reflected this ordered medication regimen was administered from 1/8/22 - 1/14/22. The order for Cephalexin entered was incorrect when compared to the After Visit Summary, and the dose administered was incorrect.

A review of the facility's policy, 6.0 General Dose

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F 760	Continued From page 56 Preparation and Medication Administration, revised 1/1/22, reflected: "4. Prior to administration of medication ... 4.1 Facility staff should: 4.1.1 Verify each time a medication is administered that it is the correct medication, at the correct dose ... 4.1.2 Confirm that the MAR reflects the most recent medication order ..."	F 760		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the	F 801		4/3/22

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supervision of a registered dietitian or nutrition professional.
(iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for

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F 801	Continued From page 58 food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide oversite for a Dietary Manager who was not certified. This deficiency affected 1 (#38) of 1 sampled resident, and any resident consuming food from the kitchen. Findings include: During an interview on 2/14/22 at 3:28 p.m., staff member G stated he was not sure if he was a Certified Dietary Manager. A Dietary Manager certificate was requested, no information was provided by the end of the survey. During an interview on 2/15/22 at 8:28 a.m., resident #38 stated the food at the facility was awful, cold, and there were no options to choose from. Resident #38 stated the cooks in the kitchen did not know how to cook, and the dietary manager did not know what he was doing in the kitchen. During an interview on 2/15/22 at 2:58 p.m., staff member G stated he wasn't sure how the resident allergies were addressed. The dietary staff checked the resident chart for allergies and did not serve the resident that food. During an interview on 2/15/22 at 3:14 p.m., staff member G stated he did not know the cooks	F 801	1.Resident #38 will be interviewed by Dietary Manager or designee regarding food preferences, food temperatures, mealtimes, recommended additions to consider for always available menu, and ordering/substitution process as to ensure resident has opportunity to select what they would like as well as report a concern if a meal arrives mistakenly incomplete by 4/3/22. 2.Each resident will be interviewed by Dietary manager or designee regarding food preferences, food temperatures, mealtimes, recommended additions to consider for always available menu, and ordering/substitution process by 4/3/22. 3.The facility Dietary Manager shall complete the International Food Service Executives Association (IFSEA) Certified Food Manager (CFM) by 4/2/2022, as staff member O is not currently employed by facility. New dietitian or designee shall Inservice dietary manager and staff on proper methods for obtaining food temperature as well as expectation for daily documentation of food temperatures. Dietary manager will be retrained on process for making menu changes within menu/tray card system to ensure continued proper practice with oversight provided by Linda Crandall, RD.	

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	275020	A. BUILDING _____ B. WING _____	C 02/17/2022

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F 801	Continued From page 59 needed to take and record the temperatures of cold and hot foods, before they were served to residents, to ensure the food reached/maintained a safe serving temperature. Staff member G stated he had never completed an in-service training with any of the dietary staff members. Staff member G stated they take a training on the computer upon orientation that discusses safe food handling. In-service training documents were requested for dietary staff, to include staff member G, none were provided by the end of the survey. During an interview on 2/16/22 at 3:42 p.m., staff member G stated he was not receiving very much oversite from staff member O. Staff member G stated staff member O had not come into the kitchen to provide training or oversite. He stated he had only talked to her a couple of times on the phone. During an interview on 2/16/22 at 3:42 p.m., staff member G stated he had been changing items on the menu if they do not have the original food item in stock. He stated he was not getting approval by staff member O prior to the change. Review of the Food Temperature Chart, undated, was blank.	F 801	4.NHA or designee shall review daily food temperature documentation each week for three weeks, then monthly until sustained compliance. NHA or designee shall review log of facility dietitian interactions with kitchen monthly until sustained compliance achieved. Reported in QAPI on 4/1/2022.	
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments,	F 802		4/3/22

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F 802	Continued From page 60 individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain sufficient dietary staffing to carry out duties in the kitchen. This deficiency affected any resident who consumed food from the kitchen. Findings include: During an observation on 2/14/22 at 3:40 p.m., the kitchen appeared unkept and unclean. There were various food wrappers on the floor. Dried food was in the microwave. The area around the fryer was oily, and dust was visible in the oil. Instant mashed potatoes were sitting out, unwrapped, in a bowl. Various food items in the walk-in cooler were undated and unlabeled. (See F812 for details on cleanliness, food labeling, and storage). During an interview on 2/14/22 at 3:59 p.m., staff member Y stated the kitchen had been very short staffed for a while. She stated that food preparation and cleaning did not get done because of the short staffing. Staff member Y	F 802	1.Resident #44 will be interviewed by dietary manager or designee regarding food preferences, food temperatures, mealtimes, recommended additions to consider for always available menu, and ordering/substitution process by 4/3/22. 2.Each resident will be interviewed by dietary manager or designee regarding food preferences, food temperatures, mealtimes, recommended additions to consider for always available menu, and ordering/substitution process by 4/3/22. The facility has an active recruitment program and recently hired additional new staff members. The facility has a sister facility in the community to utilize shared staff as needed and if available. 3.New dietitian or designee shall in-service dietary manager and staff on proper methods for obtaining food temperature as well as expectation for daily documentation of food temperatures. New dietitian or designee shall in-service	

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F 802	Continued From page 61 stated the kitchen staff tried to clean as much as they could and tried to remember to label food items. During an interview on 2/15/22 at 8:25 a.m., staff member BB stated he did not know food temperatures needed to be taken before the food was served to the residents. Staff member BB stated, "I don't know how to temp the food. I have never done that before." Staff member BB stated he had not had training on how to take and record the temperature of food. During an observation and interview on 2/15/22 at 8:48 a.m., resident #44 was in her room seated beside her bed, with her bedside table in front of her, and she had a clothing protector on. Resident #44 stated, "Where is my meal? It's so late." During an interview on 2/16/22 at 3:42 p.m., staff member G stated the mealtimes were at 7:00 a.m. for breakfast, 11:30 a.m. for lunch, and 4:30 p.m. for dinner. He stated the kitchen staff tried to get the food out at that time, however, the kitchen was short staffed. Staff member G stated two additional cooks were in the hiring process. Staff member G stated due to staffing issues in the kitchen the facility had to make a few changes to the foods served to minimize preparation time. Staff member G stated the kitchen had started serving canned vegetables instead of fresh vegetables, and had switched to simpler desserts that did not take as long to make and prepare. Staff member G stated staff member E was from maintenance, but he had been stepping in to cook because the facility did not have enough cooks. Staff member G stated he expected the kitchen staff to clean the kitchen, but he had not	F 802	dietary manager regarding menu product selection to ensure such that meals provided for residents maintain desired palatability and nutritional value. New dietitian or designee shall in-service dietary manager and staff regarding timely meal production consistent with the facility□s scheduled mealtimes. DON or designee shall in-service nursing floor staff regarding timely distribution of meal trays consistent with the facility□s scheduled mealtimes by 4/3/22. 5.NHA or designee shall audit meal service for time that meal distribution begins, timely distribution of trays from cart to resident room, and the time that meal distribution ends. Temperature of the final tray delivered shall be documented. This audit will be conducted at five meals per week for three weeks, then monthly for four months. NHA or designee shall interview five residents regarding timely meal delivery and palatability each week for three weeks, then monthly for four months. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 802	Continued From page 62 provided a cleaning check list for the staff members. Staff member G stated he had been changing items on the menu if they do not have the original food item in stock. He stated he was not getting approval by staff member O prior to the change. Review of the facility's Daily Cleaning Schedule, undated, for the kitchen was blank.	F 802		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain hot foods at a palatable temperature for 8 (#s 9, 12, 14, 20, 38, 47, 56 and 60) of 15 sampled residents. This deficiency had the potential to affect any resident who consumed food from the kitchen. Findings include: During an interview on 2/15/22 at 8:25 a.m., staff member BB stated he did not know food temperatures needed to be taken before the food was served to the residents. Staff member BB stated, "I don't know how to temp the food. I have never done that before." Staff member BB stated he had not had training on how to take and record	F 804	1.Residents #20, 9, 56, 12, 38, 14, 60, and 47 will be interviewed by dietary manager or designee regarding food preferences, food temperatures, mealtimes, recommended additions to consider for always available menu, and ordering/substitution process on or before 4/3/2022. 2.Each resident will be interviewed by dietary manager or designee regarding food preferences, food temperatures, mealtimes, recommended additions to consider for always available menu, and ordering/substitution process on or before 4/3/2022.	4/3/22

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F 804	Continued From page 63 the temperature of food. During an observation on 2/15/22 at 8:30 a.m., staff member DD took the temperature of resident #20's eggs from his room tray right before he served it to resident #20. The temperature was 91 degrees Fahrenheit. During an observation on 2/15/22 at 8:37 a.m., staff member K took the temperature of resident #9's eggs. The temperature was 90 degrees Fahrenheit. During an interview on 2/15/22 at 8:47 a.m., resident #56 stated the food on her room trays were always cold. She stated she had to get used to eating cold eggs because she did not have a choice. During an interview on 2/15/22 at 3:14 p.m., staff member G stated he did not provide any training to dietary staff on recording or taking food temperatures. A review of the facility's policy, Food Temperatures, dated 2/1/2016, showed: "...1. Using a food thermometer, obtain final temperatures for all menu items, hot and cold, prior to serving ... 2. Temperatures for hot products should be no less than 135 F to keep food out of temperature danger zone. Cold products shall reach temperatures no greater than 41 F. Foods failing to register these temperatures must be reheated/chilled until acceptable temperatures are reached (hot foods minimum 165 for 15 seconds/cold foods <41) 3. Serving temperatures will be recorded by the	F 804	3.A new dietitian or designee shall in-service dietary manager and staff on proper methods for obtaining food temperature as well as expectation for daily documentation of food temperatures. Dietary manager to attend resident council and review progress with menus, mealtimes, temperature, and palatability. Council remarks logged in minutes to be reviewed with administrator with follow-up to those remarks documented and attached with resident council minutes. New dietitian or designee shall in-service dietary manager regarding menu product selection to ensure such that meals provided for residents maintain desired palatability and nutritional value. All education will be completed by 4/3/2022. 4.NHA or designee to review resident council minutes each month for resident comments and follow-up for 3 months until sustained compliance achieved. NHA or designee shall interview five residents regarding timely meal delivery and palatability weekly for 4 weeks, then 3 residents per week for 4 weeks, then 5 residents monthly for 2 months until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 804	Continued From page 64	F 804		

cook or other designated personnel for all items prior to serving on a temperature log. ..."

Review of the Food Temperature Chart, undated, was blank.

During an interview on 2/14/22 at 3:56 p.m., NF3 stated resident #12 did not get the food he ordered. Sometimes it was not cooked all the way. He (resident #12) ordered from the alternative menu yesterday and they did not deliver what he ordered from the alternative menu, they only brought what he ordered off the regular menu. Resident #12 stated, "The dinners are late, I had to tell them not to give me my dinner insulin until my food comes because sometimes it doesn't come until 8:00 p.m."

A review of Resident Council minutes showed:

8/10/21- "Receiving food they can't eat, or not getting what they requested."
9/14/21- "Food is still hard and cold. Food is too done or not done enough."
11/16/21- "Breakfast not arriving before dialysis. Food quality is poor, options for special diets seems non-existent."
12/14/21- "Food being cold and served late. Mealtimes- receiving lunch at 1-130 and dinner around 7-9ish. Not receiving food on menu or ticket that was ordered."
1/13/22- "Consistent times of meal, food is better, still have some trouble with tough food."

During an interview on 2/15/22 at 8:28 a.m., resident #38 stated the food was awful and cold, there were no options, the cooks did not know how to cook, and the dietary manager did not know what he was doing in the kitchen.

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F 804	Continued From page 65 During an interview on 2/14/22 at 3:44 p.m., resident #14 stated the food arrived cold most of the time. Resident #14 had voiced concerns to dietary and to staff member B about the cold food. During an interview on 2/15/22 at 8:15 a.m., resident #60 said the food was always cold and meals were not on time. During an interview on 2/15/22 at 9:01 a.m., resident #47 stated the dinner meal on 2/14/22 was a grilled cheese sandwich with french fries topped with cheese. The sandwich was burnt and the french fries with cheese were a "lump of mush." Resident #47 said the meal cart arrived and sometimes it sat for an hour before meal trays were distributed to the residents. During an interview on 2/15/22 at 10:45 a.m., resident #9 stated the food was often cold and late to arrive. Resident #9 said she would be given her medication and got an upset stomach when the meals arrived late. Resident #9 liked to order soup and said her soup often had black flakes floating on top and meals were often burnt.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat	F 806		4/3/22

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F 806	Continued From page 66 food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide adequate food options to accommodate residents with allergies and intolerances, and failed to consider residents preferences for 2 (#s 16 and 51) of 5 sampled residents. Findings include: 1. During an interview on 2/14/22 at 3:53 p.m., resident #16 said, "I am allergic to wheat and dairy and that knocks out a lot of the food they (the facility dietary departement) serve. The dietary area said they would accommodate it, but that hasn't happened." Resident #16 stated she preferred not to eat a lot of meat, and the facility served a lot of meat. During an interview on 2/15/22 at 2:58 p.m., staff member G stated he wasn't sure how the allergies were addressed. The dietary staff checked the resident chart for allergies and did not serve the resident that food. When asked what the facility had to accommodate resident #16's allergies, staff member G said the facility had coconut milk, frosted flakes, and rice cereal. Staff member G said, "I may need to order some gluten free cereals and foods." During an interview on 2/15/22 at 3:25 p.m., resident #16 stated she selected her own meals from the alternate menu. Resident #16 said the selection was very limited and her meals consisted of corn cereal, salad, and lunch meat. Resident #16 provided her own nut butter, and sometimes gluten free bread brought by friends.	F 806	1.Facility unable to identify resident #16 as they are not included on facility sample list. Resident #51 will be interviewed by dietary manager or designee regarding food preferences, food temperatures, mealtimes, recommended additions to consider for always available menu, and ordering/substitution process on or before 4/3/2022. 2.Each resident will be interviewed by dietary manager or designee regarding food preferences, food temperatures, mealtimes, recommended additions to consider for always available menu, and ordering/substitution process on or before 4/3/2022. 3.New dietitian or designee will audit each current resident□s EMR listed allergies vs tray card system for accuracy. Residents with any identified exceptions to be interviewed to provide education and ensure understanding of listed allergies with their tray cards and care plans to be updated accordingly. New dietitian or designee to in-service dietary manager and staff regarding review of resident allergies and how to handle those exceptions during meal production/distribution. All education will be completed on or before 4/3/2022. 4.New dietitian or designee will audit EMR of that week□s new admissions for food allergies compared to their tray card records for accuracy. This audit will be conducted weekly for three weeks then	

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F 806	Continued From page 67 During an interview on 2/16/22 at 10:17 a.m., staff member O stated, food allergies were not at the top of the facility's list to accommodate. The CNA and kitchen staff would check the resident's diet and if the food was incorrect, will discard the food, and notify the kitchen. Staff member O said the CNAs did not know the different diets and needed training. Staff member O stated, "My recommendations are not followed or considered. Wounds, allergies, diabetic or dialysis menus all need work. I am not allowed to go into the kitchen, the staff is new and just doesn't know." A record review of the facility's "LGHC Dietary evaluation," dated 9/8/21, by staff member NN, showed, "[Resident #16] reports anaphylactic allergies to basil and shellfish with intolerance to wheat and dairy. Resident also avoids multiple foods that produce migraine triggers." A record review of resident #16's diet order listing report, dated 4/15/19, showed an order for a regular diet, regular texture, thin liquids consistency, allergic to shellfish, basil, chocolate, cheddar, strawberries, peanuts, and ranch. Resident #16's allergies included basil, cheddar, chocolate, gluten, milk, peanuts, ranch dressing, shellfish and strawberries. Resident #16 had no beverage preferences identified. Dislikes included: all dairy products, chocolate, cheeses, ham, no wheat cereal, peanuts, pasta, potatoes, ranch dressing, strawberries, and wheat bread. The facility's "Selection Sheet," dated 2/15/22, showed resident #16 had a regular diet with double meat portions. Lunch meal options were: mixed vegetables and a choice of beverage. Resident #16's lunch options did not include a meat option.	F 806	monthly for four months. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 806	Continued From page 68	F 806		

A record review of resident #16's care plan, dated 1/14/22, showed:

" ...Honor food preferences per facility ability. Initiated: 3/10/21
No wheat bread, no wheat cereal and no milk based dairy products as I have complaints of tight throat, red face and rash when I consume these foods. Initiated 5/15/21 ..."

2. During an observation and interview on 2/15/22 at 9:15 a.m., resident #51 received his breakfast consisting of two eggs, one cup of yogurt, and a cup of orange juice. Resident #51 stated he did not receive the 2 oz of ham he requested, and this was not the first time it had happened. The resident stated missing food items occurred about six out of ten times. Review of the resident's food selection card, on the resident's food tray, showed the resident requested 2 oz of ham, in addition to two eggs, yogurt, and orange juice.

Review of resident #51's Care Plan, dated 10/24/21, reflected, "Honor food preferences per facility ability providing an alternate menu PRN. ..."

A record review of the facility's "Alternate Menu choices and Always Available Menu," not dated, showed:

"Sandwiches: Hamburger or Cheeseburger, Hot Dog, Tuna or Egg Salad, Deli Sandwiches, Bacon, Lettuce and Tomato.
Salads: House, Chef, Fruit Plate, Cold Meat and Cheese Plate
Sides: Potato Chips, Fruit Cup, Cottage Cheese,

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F 806	Continued From page 69 Vegetable of the Day, Relish Plate, French Fries Desserts: Pudding, Ice Cream, Dessert of the Meal Soups: Soup of the Day, Chicken Noodle Hot Entrees: Personal Pizza (Cheese, Pepperoni, and Sausage), Corn Dog, Bean Burrito, French Dip w/au jus, Fish Sticks Availability Subject to Change."	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to label and date food items, as well as maintain a sanitary environment in the kitchen. These deficient practices had the potential to affect any resident consuming food from the kitchen. Findings include:	F 812	1.No resident-specific findings applicable. 2.Each element of identified concern places all residents at risk. 3.Sign off sheet to be added to daily, weekly, monthly cleaning sheets. New dietitian or designee to in-service dietary	4/3/22

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F 812	Continued From page 70 During an observation on 2/14/22 at 3:40 p.m., the following was found in the kitchen: - There were white crumbs and various paper garbage items on the floor, and the area under the fryer was greasy with crumbs on the counter. Under the fryer, on the shelf, there were crumbs stuck in grease. - 11 small bowls of a fruit mixture, not covered or dated, were in the refrigerator fridge by the fryer, - 1/2 of a cucumber, and two halves of tomato in saran wrap, were not dated, - A one-gallon bag of hot dogs was left open, and not sealed, - 10 hard boiled eggs with no date and no label, - A small bowl of link sausage, with no date and no label, - A Ziplock bag of minced onions with no date and no label, - 10 eggs in plastic, not sealed, in a metal bowl, without a date, - A small bowl of instant mashed potatoes was on the table next to the fryer with a spoon in it, without a cover, - The microwave had yellow dried food inside, on the plate, and on the sides of the microwave, - 1/2 carrot in a bowl was not sealed or dated; and, - A bag of instant potatoes was located under the fryer, on a shelf, unsealed. Walk in freezer: - 3 boxes of food stored on the floor: Brussel sprouts, bread, mac and cheese, and - 3 bags of hot dog buns were on the floor of the freezer.	F 812	manager and staff for food labeling and dating, appropriate storage of food, and cleaning tasks with their associated sign off sheet on or before 4/3/2022. 4.NHA or designee accompanied by the dietary manager to perform visual inspection of the kitchen once per week for three weeks then monthly for four months. NHA or designee to audit all cleaning sign off sheets for completion once per week for three weeks then monthly for four months. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 812	Continued From page 71 Walk in refrigerator: - Egg salad, 5 lb, with no date, - ricotta cheese, 5 lb, with no date, - red raspberry dessert topping, 7 lb, with no date, - 2 small tortillas, no label, not dated, - 1/2 of a tomato, with no date, - 1 gallon of mayo, without an open date, - 1 gallon of ranch dressing, with no open date, - A sheet pan of what appeared to be bread, without a label or date, - A gallon of milk, without a date; and, - 2 pitchers of a creamy mixture, without a label or date. During an interview on 2/14/22 at 3:59 p.m., staff member Y stated staff were supposed to label and date food items when they put them in the refrigerator. Staff member Y stated items placed in the refrigerator by the fryer were not sealed so it was easy to grab the items quickly. Staff member Y stated the kitchen got cleaned daily, but there was not a sign off sheet to show when the items in the kitchen were cleaned. Staff member Y stated, "If its dirty, we clean it." During an interview on 2/14/22 at 4:13 p.m., staff member G stated all items in the refrigerator should have a date of when the item was made or opened. He stated the kitchen had an a.m. and p.m. cleaning schedule, however, there was no sign off sheet to monitor that the items on it were being cleaned. Review of the facility policy titled, Kitchen, revised on August 1st, 2019, showed, "...e. Refrigerated food should be covered, dated, labeled, and shelved to allow air circulation ..."	F 812		

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F 881	Continued From page 72	F 881		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a consistent antibiotic stewardship program, including infection surveillance. This deficient practice had the potential to negatively affect residents taking antibiotics for infections, and increase the incidence of adverse events associated with infections and antibiotic use throughout the facility. Findings include: During an interview on 2/16/22 at 1:53 p.m., staff member B stated the facility's previous DON had not kept track of the line listing and antibiotic stewardship for the residents, and she was working on the infection listings for the month of February. Review of the facility's Infection Control binder reflected a lack of antibiotic stewardship and infection mapping for December 2021 and January 2022. February 2022 included a map of infection types. The months prior to December 2021 included infection mapping, line listings, and antibiotic use.	F 881	1.Line listing and mapping completed for December 2021, January 2022, and February 2022 by 4/3/2022. 2.All residents have the potential to be affected. 3.Incorporated daily antibiotic tracking in morning clinical meetings. Nurse leadership educated on Antibiotic Stewardship Program. Nursing staff educated on infection control program and antibiotic stewardship program by DON or designee. All education completed on or before 4/3/2022. 4.NHA or designee to audit ASP mapping, antibiotic tracking, and reporting of antibiotics in morning meeting weekly for 12 weeks until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	4/3/22

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F 881	Continued From page 73 A review of the facility's policy, Antibiotic Stewardship Program (ASP), revised January 2021, reflected: "Background: ...According to the CDC, "Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. Diseases caused by these bacteria are increasing in long-term care facilities and contributing to higher rates of morbidity and mortality. [sic] Policy ...This Long-Term Care Facility ASP activities shall, at a minimum, include these basic elements: ...tracking measures, reporting data. Procedure: ... 2. Accountability a. The ASP Team ...will: i. Review infections and monitor antibiotic usage patterns on a regular basis ... iii. Monitor antibiotic resistance patterns ... iv. Report on number of antibiotics prescribed and the number of residents treated each month v. Include a separate report for the number of residents on antibiotics that did not meet criteria for active infection. ..."	F 881		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §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	F 888		4/3/22

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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 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

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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 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

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F 888	Continued From page 76 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 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 failed to ensure staff had a vaccine, exemption, or a delay for the COVID-19 vaccine, at a rate of	F 888	1.On 2/17/2022 100% of staff had an exemption in place or first dose of vaccine.	

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F 888	Continued From page 77 100%, for 2 (staff members U and V) of 7 sampled staff members. This deficiency had the potential to increase the incidence of COVID-19 amongst residents and staff in the facility. Findings include: During an interview on 2/16/22 at 1:53 p.m., staff member B stated staff members U and V did not have a COVID-19 vaccine, exemption, or delay, and were in the process of getting their first vaccines. Staff member B stated staff member KK was following up with the staff members who were not compliant with the vaccines, and that all staff were wearing appropriate PPE for the current outbreak in the facility. Staff member B stated if staff members U and V chose not to receive the COVID-19 vaccine or obtain an exemption, they would be unable to work in the facility. Review of the facility's document, COVID-19 Staff Vaccination Status for Providers (Matrix), received on 2/15/22 at 7:30 a.m. by staff member A, reflected staff members U and V were not showing as having a COVID-19 vaccine, exemption, or delay. The total number of staff was recorded at 101, and the facility was 99% compliant with staff vaccinations. Review of the facility's document, Current COVID Outbreak, received on 2/15/22 at 7:30 a.m. from staff member A, reflected 13 residents infected with COVID-19 in the past four weeks. The document reflected three of those infections resulted in a hospital stay, and one resulted in a resident's death. A review of the facility's policy, COVID-19 Vaccination - Healthcare Personnel (HCP),	F 888	2.DON or designee will conduct an audit of staff records for vaccine or exemption on or before 4/3/2022. 3.Staff will not start employment until vaccine status or exemption in place. Regional Nurse Consultant or designee will provide education to HR, NHA, and DON to COVID vaccine policy on or before 4/3/2022. 4.NHA or designee to audit staff vaccination status weekly until sustained compliance achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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F 888	Continued From page 78 revised 2/7/22, reflected: "Policy: ... 1. ...HCP will ...be mandated* to receive the COVID-19 vaccine unless they have submitted and been granted a religious or medical exemption or they have already received the current recommended vaccine(s), ..."	F 888		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an adequate call system was in place due to a non-functioning call light system, so residents could alert staff when assistance was needed, and get a timely staff response, for 12 (#s 3, 8, 21, 23, 27, 28, 29, 30, 34, 39, 41, and 53) of 34 sampled residents. Resident #53 felt a contributing factor for a fall he had was due to the lack of staff response and the call system, and the lack of response to the bell system caused resident frustration and delays in care. Findings include: 1. During an interview on 2/14/22 at 3:53 p.m., resident #29 stated he had to ring a bell on his desk, instead of a call light, and it took a while, sometimes hours, for the staff to answer.	F 919	1.Call light system repair ordered on 1/14/22. Installation of new call light system on or before 4/3/2022. 2.All residents on affected unit at risk. Maintenance Director or designee will conduct an audit of all call lights in other area of facility ,testing for function by 4/3/2022. 3.DON or designee will provide education to staff on call light outages and plan on managing call light outages on or before 4/3/2022. 4.Maintenance Director or designee to audit residents call light system with random testing of 10 resident rooms per week for 4 weeks, then 10 rooms monthly for 2 months until sustained compliance	4/3/22

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F 919	Continued From page 79 2. During an interview on 2/14/22 at 3:56 p.m., resident #21 stated he had a bell to use instead of a call light, and staff did not always answer quickly. Resident #21 stated he had to wait over an hour for staff to answer at times. 3. During an interview on 2/14/22 at 4:00 p.m., resident #8 stated the residents did not have a call bell, and there were times when they had to wait a while for help. Resident #8 stated she did not know when the situation with the call lights would be fixed. 4. During an interview on 2/14/22 at 4:05 p.m., resident #41 stated instead of a call light, she had a bell to call for help. The resident stated if the bell did not get answered, most of the time she would stick her leg outside of her door to get the staff's attention when she needed help. 5. During an interview on 2/14/22 at 4:10 p.m., resident #3 stated he had to wait a while when he rang his bell because the facility was short staffed. Resident #3 stated he went into the hall and flagged down a staff member if his roommate, resident #53, needed help because the staff were taking too long. Resident #3 stated this was a common occurrence. 6. During an interview on 2/14/22 at 4:10 p.m., resident #53 stated the residents had bells to use instead of a call light, and it did not work very well. Resident #53 stated he could ring the bell all day, and the staff did not come at times. Resident #53 stated there was a time where he had to wait a while and fell on his bottom when he was trying to pick a remote up off of the floor.	F 919	achieved. Results of audits will be reported to QAPI committee by 4/1/2022 for discussion and development of corrective action if needed to sustain compliance.	

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7. During an observation and interview on 2/14/22 at 4:17 p.m., resident #27 was sitting in his room, with the door slightly open, using his bell to alert the staff that he needed assistance. Resident #27 stated there was no way for a staff member to know his bell had rung unless they heard it. The resident stated he usually had to wait a while, the bell system did not work well, and he had to ring the bell until his arm was sore.

During an observation on 2/14/22 at 4:36 p.m., resident #27 continued to ring his call bell, and the closest staff member was down the hallway by the med cart. When the surveyor went to the med cart, the bell sound was barely audible. The surveyor left the hallway after 19 minutes, and resident #27 did not receive a response from staff for the ringing of his bell.

8. During an interview on 2/15/22 at 9:06 a.m., resident #30 stated instead of a call light, the facility had him use a tambourine when he needed help. Resident #30 stated when he made noise, the staff did not come quickly.

During an interview on 2/16/22 at 9:59 a.m., staff member N stated the call light system had been out of service for almost two months. Staff member N stated the facility was experiencing an increase in resident falls because the residents were trying to reach their bells. Staff member N also stated it caused the residents to be unhappy, and it was a hazard because the staff could not see who was ringing, or tell who needed help if the resident stopped ringing.

9. During an observation and interview on 2/15/22 at 8:15 a.m., resident #28 was seated in her wheel chair next to her bedside table. On her

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bedside table there was a bell. Resident #28 stated the facility's call light system was not working. She stated it had been broken for a long time now. She stated she was given a bell to ring when she needed something, however staff members could not hear the bell or did not know which resident was ringing the bell. Resident #28 stated she had felt frustrated because she had to wait a long time for a staff member to come and help her.

10. During an observation and interview on 2/14/22 at 4:01 p.m., it was observed resident #34's call light was hanging on a metal hook that was screwed into the bookcase up against the wall on the left side of the resident's bed. The call light was above and behind the resident's head. The resident had a hand bell sitting on table next to his bed. Resident #34 said the call lights had not been working for several weeks, probably a month, so staff gave him the hand bell to ring if he needed help. When asked if ringing the hand bell was affective, the resident said, "No, they can't hear anything in the hallway or if they're in another resident's room." When asked how he made staff aware he needed something resident #34 said, "I yell, usually someone hears me."

11. During an observation and interview on 2/15/22 at 7:20 a.m., resident #23 was in her wheelchair watching television. She had a bedside tray table pulled over her lap. Sitting on the table was a bell, similar to a hotel desk bell. Resident #23 said she was waiting for breakfast. When asked about the bell on her table, she said she was supposed to ring it for help. Resident #23 said the facility call lights had not worked in a "long time." When asked if staff answered the bell the resident said, "No, they can't hear it."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	275020	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA OF BILLINGS	1807 24TH ST W BILLINGS, MT 59102

(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 919	Continued From page 82	F 919		

Resident #23 expressed frustration with the situation. Resident #23 said she needed help going to the bathroom, and it was hard to get staffs' attention when they could not hear her ringing her bell.

12. During an observation and interview on 2/15/22 at 7:53 a.m., resident #39 had a hand bell sitting on his bedside table and he was in his recliner. When the resident was asked about the purpose of the bell he said the call light system was not working, and he was supposed to ring the bell for staff assistance. Resident #39 said the call lights had not been working for a month. When asked if the hand bell was affective in getting the staff's attention the resident said, "No, they can't hear it. It's too noisy out there." When asked what he did to get staff's attention for help resident #39 said, "I get in my wheelchair, roll to the door, and yell for help."

13. During an observation on 2/16/22 at 2:18 p.m., A resident in room 201 was ringing a bell in the room, then room 208 began to ring a bell. At 2:21 p.m., a staff member entered room 204 after walking down the hall trying to figure out what room was ringing the bell. At 2:22 p.m., room 208 began ringing the bell again. A staff member walked by the room and went into room 212 to ask if they needed help. The resident stated, "No, I don't know who is ringing." At 2:23 p.m., room 208 was still ringing the bell. The wound care nurse walked by wearing her coat to leave, she told the resident that she would be back to help. At 2:25 p.m., the wound nurse returned and helped the resident. At 2:27 p.m., there was someone ringing a cow bell on the 200 hall, it was hard to tell where it was coming from. No staff entered any of the rooms, but the cow bell

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	275020	A. BUILDING _____ B. WING _____	C 02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA OF BILLINGS	1807 24TH ST W BILLINGS, MT 59102

(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 919	Continued From page 83 stopped ringing. Observation ended at 2:56 p.m. During an interview on 2/16/22 at 2:47 p.m., staff member K stated, "You just have to keep walking up and down the halls until you can figure out who is ringing the bell."	F 919		