STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS	F 000		

A Recertification survey was completed by the Department of Health and Human Services, Office of Inspector General, Certification Bureau, on 3/31/21. Facility Reported Incidents were investigated during the survey.

The facility census on entrance was 57.

DEFICIENCIES CITED:
Refer to FORM CMS-2567; Event ID: EBJY11 for findings.

Deficient practices were cited for the Recertification survey.

Deficient Practices were cited for Facility Reported Incident(s) with Intake Number(s): #MT00052522 and MT00052605.

DEFICIENCIES NOT CITED:
Refer to FORM CMS-2567; Event ID: BY3411 for findings.

Deficient practices were cited for the Recertification survey.

Deficient Practices were NOT cited for Facility Reported Incident(s) with Intake Number(s): #MT00051152 and MT00052532.

IMMEDIATE JEOPARDY

On 3/29/22 at 4:49 p.m., the facility Administrator was notified that an Immediate Jeopardy existed in the area of F689: Free of Accident Hazards /supervision/devices, for smoking.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/24/2022

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

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F 000	Continued From page 1	F 000		

Severity and Scope identified for the Immediate Jeopardy was identified to be at the level of J, and upon removal of immediacy lowered to an G.

Resident #36 sustained facial burns and other smoking injuries. Resident #36 had smoked in his room putting him and other residents at risk for serious harm. Resident #36 does keeps his cigarettes and lighters unsecured in his room. Resident #36 lacks safety awareness and is not supervised or monitored for his smoking. Resident #36 wears oxygen. The facility lacks policies and procedures regarding safe smoking for residents though they are aware of the resident smoking in and out of the non-smoking facility. The facility has failed to implement interventions for the ongoing smoking of the resident, even after he sustained an injury in May 2021.

The facility did submit and acceptable plan to remove the immediacy on 3/31/22 at 10:30 a.m.

PLAN TO REMOVE IMMEDIACY

A summary of the facility's plan to remove the immediacy was as follows:

"1. Smoking evaluation completed 03/29/2022. IDT reviewed assessment and deemed safe to smoke with supervision on 03/29/2022 @2000. Resident #36 will have supervised smoking in the TLC courtyard where there is a smoking blanket, cigarette buttress, and fire extinguisher; smoking items to remain locked in the nurses cart or med room; skin assessment completed, will not wear oxygen when smoking; will not smoke in room; care plan updated to include elopement and

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F 000	Continued From page 2 smoking interventions/safety risks; a comprehensive smoking assessment, 1: 1 supervision with storage of smoking items (lighter) and a current BIMS. On 03/30/2022, an order was obtained to allow the resident to leave the building on pass from the provider. New Resident sign in/out sheet implemented for resident and responsible party to go out to smoke and for outings to include resident's destination, 1: 1 staff signature, Nurse signature, date and time, resident signature and confirmation of returning smoking paraphernalia to nursing staff to secure. 1 : 1 visual supervision will be in place for duration of his stay at all times until discharge from the facility. If resident is non-compliant with the plan in place, progressive action will take place up to notice of discharge to ensure all residents' safety. 2. Designated smoking times will be 7a, 11a, 3p, 7p, and 11p. 3/30/22, with assigned staff member. Education was provided to staff on shift for evenings and oncoming night shift staff 3/29/22 and 3/30/22, the 1 : 1 will be able to visualize resident when in room and will be 24 hour supervision until he becomes compliant with storage of lighter/matches with the nurses storing them in the med cart. SDC initiated education 1 :1 'son being able to visualize resident at all times. supervising smoking, and to remain with resident, to report any concerns of non-compliance to supervisor immediately. He is monitored by a 1 : 1. Nurse to give resident his lighter/matches when he goes out to smoke. 1: 1 will ensure the nurse received the items back. 1: 1 to ensure resident takes oxygen off for 5 minutes prior to going out to smoke. Smoking evaluations will be completed quarterly or with change of condition. Skin assessments are completed weekly and	F 000		

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F 000	Continued From page 3	F 000		

PRN with new skin concerns. Education initiated on 03/30/2022 on the revised sign in/out sheet to staff and resident.

3. ED and DDCO re-educated resident verbally on 3/29/22 on risk to others and is documented. He refuses to sign anything. Nurses and 1:1 will ensure supplies are locked up in the cart. Other residents were at risk due to resident 36's non-compliance. Agency staff and new staff will be educated on resident #36's smoking plan prior to start of their first scheduled shift. Therapy completed Mocha on 3/30/22.

4. Administrator will oversee the smoking policy and compliance with the smoking policy. Administrator was educated on the Empres Resident Smoking Safety Policy by DDCO on 03/29/2022. The administrator will review compliance with the clinical team 5 times per week during clinical meeting. Any non-compliance noted during clinical meeting an IDT review will be completed. Administrator will report compliance/non-compliance to QAPI monthly. Revision dates for the policy reviewed and updated as needed. Training on the policy for staff on shift those days with other staff to be educated prior to their next shift was completed on 03/29/2022 and 03/30/2022. Education will be provided to new hires and agency staff prior to start of first scheduled shift. Fire education started on 3/30/22 with all staff scheduled and other staff to be educated prior to next scheduled shift. All staff will get fire education.

5. Other residents will be interviewed to determine understanding of the smoking facility policy; smoking policy is signed and in medical record; and staff will be interviewed to see if any

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F 000	Continued From page 4	F 000		

other residents have been smoking. Residents were interviewed on 3/29/22 with no others identified. No other residents were identified to smoke or be non-compliant. The interviews were documented on a form on 3/29/22. QAPI was held on 03/30/2022 to address the plan for removal of immediacy.

6. AGACNP-BC, MSN (Adult Gerontology Acute Care Nurse Practitioner-Board Certified, Masters of Science in Nursing), Vice President of Clinical Operations for Empres Healthcare educated Divisional Directors of Clinical Operations on Empres Resident Smoking Safety Policy, on 03/29/2022. Director of Nursing Services was re--educated on 03/29/2022 by DDCO on Empres Resident Smoking Safety Policy and Empres Abuse, Neglect, or Exploitation Policy regarding resident safety. On 03/29/2022, the Divisional Director of Clinical Operations provided education to Director of Nursing and Executive Director using: Empres Resident Smoking Safety Policy and Empres Abuse, Neglect, or Exploitation Policy. Director of Nursing educated the following RN's on 03/29/2022 MOS Coordinator, Staff Development Coordinator, Resident Care Manager and Assistant Director of Nursing. All staff will be educated on the policy prior to their next scheduled shift. Staff that worked evening and night shift on 3/29/22 were educated on 3/29/22. Residents will be educated on 3/30/22 on the smoking policy. New staff and agency staff will be trained on fire safety/procedure prior to their 1st scheduled shift.

Compliance date 3/31/22 at 10:30 a.m. for the removal of immediacy." [sic]

Abbreviations:

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F 000	Continued From page 5 1:1 One to One Caregiver Monitoring ARD Assessment Reference Date BIMS Brief Interview of Mental Status cm centimeter CMS Centers of Medicare and Medicaid CNA Certified Nurses Assistant DDCO Divisional Director Clinical Operations DNR Do Not Resuscitate ED Executive Director GDR Gradual Dose Reduction IDT Interdisciplinary Team MAR Medication Administration Record MDS Minimum Data Set mg Milligrams ml Milliliters MOCA Monreal Cognitive Assessment PRN As needed QAPI Quality Assurance and Performance Improvement RN Registered Nurse SDC Staff Development Coordinator SNF Skilled Nursing Facility W/C Wheelchair	F 000		
F 578 SS=F	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		5/15/22

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F 578	Continued From page 6 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to educate contract staff to the location of the advance directive binder. This deficient practice had the potential for the wrong treatment to be given in the event of an emergency for all residents with a DNR code status. Findings include: During an observation and interview, on 3/29/22	F 578	1. Agency staff was shown the location of the Advance Directive binder at the time of survey on 3/29/22. 2. All residents had the potential for risk. Executive Director or designee will validate other staff know where the advance directive binder is located at the time of hire or upon first shift at the facility by 5/15/22.	

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F 578	Continued From page 7 at 9:19 a.m., staff member D looked for the advanced directive binder at the Timbers nursing station and stated she did not know where it was located. She then asked staff member E where it was located, and staff member E identified it on the desk of the Timbers nursing station. During an interview on 3/29/22 at 9:34 a.m., staff member D stated "This is my second day working here, the unit manager trained me yesterday on patient care and passing meds. They did not tell me where the advanced directive binder is located." During an interview on 3/29/22 at 9:45 a.m., staff member C stated "I have contracted with [Company] three times before at different facilities, and they probably showed me where the advance directives binder was the first time, but they did not show me this time at this facility. The other facilities I worked at, the binder was red and the binder at this facility is burgundy colored." During an interview on 3/31/22 at 9:20 a.m., staff member F stated all nursing staff is oriented to the location of the advance directive binder during their initial training. During an interview on 3/31/22 at 10:28 a.m., staff member B stated a traveler (contracted staff) is assigned to a nurse on med cart for training, and stated, "I know the nurses are told where the advanced directives are, I don't know if the CNA's are told." There is no formal check list for travelers, we just started using travelers in this building.	F 578	3. Executive Director (RN) or designee will change the advance directive binder to a red binder that is labeled Advance Directives on the spine of the binder. The binder will be located at each nurse's station. Staff will be re-educated on the location of the advance directive binder on or before 4/29/22. New hires and agency staff will be educated on the first day of employment at the facility. 4. Executive Director or designee will audit 5 staff members to validate the staff member know where to find the Advance Directive binder weekly x4 weeks, then monthly x 2 months. Audits will be brought to QAPI on or before 4/28/22 to identify trends and sustainability, then monthly thereafter. 5. 5/15/22	
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12	F 602		4/24/22

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F 602	Continued From page 8 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish an effective monitoring system narcotic medications received from the pharmacy, which resulted in misappropriation of resident property for 5 (#s 101, 102, 103, 104, and 105) of 5 sampled residents. The facility had an excess of medications delivered by the pharmacy, which increased the risk due to medication availablity. Findings include: During an interview on 3/31/22 at 10:22 a.m., staff member B stated there was a medication diversion that involved NF2. Staff member B stated they had completed a whole house audit with the pharmacy and education was performed. Staff member B stated the facility had tightened up the security on pharmacy deliveries. Staff member B stated the pharmacy now sends reports of Cubex machine medication pulls and they perfrom random sweeps looking at the narcotic ledger books. Staff member B stated he was unsure on the exact dates of when the drug diversion involving NF2 occurred. During an interview on 3/31/22 at 12:09 p.m., staff member G stated there was a medication diversion that occurred in October 2021 that involved NF2. She stated the director of nursing	F 602	Past noncompliance: no plan of correction required.	

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was on vacation and she was responsible for the nursing department at the time. Staff member G stated it was a big investigation and all nurses were looked at; it was a very stressful time. Staff member G stated they had to change the whole process for counting narcotics. Now they monitor the narcotic count pages because some of the pages were missing. Staff member G said at the time of the investigation, the narcotic count books were pulled and transferred to new books with what medications were on the cart. Staff member G stated now the system requires two staff members, one nurse that was coming on shift and one coming off the shift to count the pages, cards, and medications. She said both nurses must sign off on the count, and notify the director of nursing if there are any discrepancies, immediately.

During an interview on 3/31/22 at 12:20 p.m., staff member P stated the medication diversion all started with a tampered fentanyl patch. There was a package but no patch. She said there was a full investigation done that included notification of law enforcement and the board of nursing. Staff member P stated an audit was conducted and documents were supplied to the board of nursing as there were several discrepancies found.

Review of Facility Reported Incident, dated 10/21/21, showed:

- "Pharmacy audit indicates missing medication for two residents. Investigation started."
- The two residents listed were Resident #103 and Resident #104
- No accused parties were noted.

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Review of a Pharmacy Audit Report, dated 10/21/21, showed:

- "Timbers 2 and 4: Item count completed. However, on Cart 4 there were narcotics that were not signed in as received from Pharmacy so the count was not accurate. (Specifically, item count was off for #103). Items need to added to ledger book when received..."[sic]

- "Morphine liquid; 2.5ml unaccounted for. Per ledger book, a bottle should be present..."
- "TLC; PAGES IN Narcotic Ledger Book missing include: Pg 27, 28 missing...Pg 41, 42 missing...Pg 59, 60 missing."[sic]

- "Following residents have medications missing based on dispensing reports from the Pharmacy, narcotic ledger books, and MAR comparison.

- 1. [Resident #104]- #44 Dilaudid 2mg tablets; delivered 10/15,
- 2. [Resident #103]- #22 Oxycodone 5mg tablets; delivered 10/4,
- 3. [Resident #105]- #16 Oxycodone 5mg tablets; delivered 9/15,
- 4. [Resident #101]- #1 Fentanyl Patch; packaging was tampered with. Center identified and reported on 10/20/21, documentation states 'opened on accident.' Total of two Fentanyl patches that were wasted for this individual."

- "Following Resident has potential of medication theft: [Resident #102] had #54 half tablets of Oxycodone IR 5mg dispensed on 9/15/21, received the medication delivery per manifest on 9/16/21. 9/17/21 however is date on ledger. Bottom of ledger is incomplete with no destruction documentation or co signatures, no medication

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was present on the cart. Resident had this medication as an active order up until discharge on 10/6/21. *"[sic]

- "Suggest that center updates the providers of the above identified effected residents as their medication quantity availability be effected."[sic]

Review of the Facility Reported Incident Findings, dated 10/26/21, showed:

- "Investigation under way for missing medications with no determination made. Education being provided in medication management to prevent future occurrences in potential cause. All residents assessed for current pain management without negative effect noted. Center continues to work with pharmacy and local officials... If additional determination is made, will submit new report and reference."[sic]

Review of a Complaint Form to the Montana Department of Labor and Industry, dated 11/3/21, showed NF2 was responsible for the medication theft and diversion.

Review of NF2's Personnel Action Form, dated 11/1/21, showed, NF2 was terminated for diversion of narcotics, with a original start date of 9/20/21.

Review of Resident #101's Medication Administration and Treatment Record, for October 2021, showed:

- The resident did not report increased pain.
- All medication was given as the physician had ordered.

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Review of Resident #102's Medication Administration and Treatment Record, for September 2021 and October 2021, showed:

- The resident did not report increased pain.
- All pain medication was given as the physician had ordered.

Review of Resident #103's Medication Administration and Treatment Record, for September 2021, October 2021, and November 2021, showed:

- The resident did not report increased pain.
- All medication was given as the physician had ordered.

Review of Resident #104's Medication Administration and Treatment Record, for October 2021 and November 2021, showed:

- The resident did not report increased pain.
- All medication was given as the physician had ordered.

Review of Resident #105's Medication Administration and Treatment Record, for September 2021, showed:

- The resident did not report increased pain.
- All medication was given as the physician had ordered.

Review of Handling Medications and Narcotics, dated 11/3/21, showed, the handling of medications and narcotics from the pharmacy and in the facility, but failed to put an effective system in place for monitoring to ensure medications and narcotics were not missing or

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F 602	Continued From page 13 stolen. .	F 602		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to investigate a facility reported event to ensure medication diversion had not occurred in the facility. This had the potential to affect residents in the facility prescribed narcotic medications. Findings Include: During an interview on 3/29/22 at 12:55 p.m., staff member A stated NF1 was working as a unit manager in the facility, at the time of the investigation for medication diversion at another building, in the company. Staff member A stated she had to suspend staff member NF1	F 610	1. Executive Director will complete an investigation for the allegation submitted on 11/23/21 by 5/15/22. 2. Any resident with a reportable incident are at risk. Executive Director will validate other facility reportable incidents from 4/1/22 through 4/24/22 have appropriate investigations completed and documented on or before 5/15/22. 3. Executive Director will re-educate the IDT on the policy of investigations including the requirements of completing and documenting a thorough investigation	5/15/22

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F 610	Continued From page 14 immediately and suspended her access to the electronic record system. Staff member A stated NF1 supposedly knew the person at the other building was diverting narcotic medications and was not sure if they tied her to the diversion. Staff member A stated NF1 was moved from the other facility during the time of the medication diversion at the other facility. Staff member A stated the facility had closed out all the narcotic ledgers, transferred them to new books, and did an audit for discrepancies or concerns, and none were found. Staff member A stated the findings were that NF1 was still on suspension as the investigation was ongoing. During an interview on 3/31/22 at 8:10 a.m., staff member A stated there was no action taken by the facility to investigate the allegation of medication diversion for NF1 specifically. Staff member A stated it was handled by another facility. During an interview on 3/31/22 at 9:27 a.m., staff member J stated the suspicion around NF1 being involved in drug diversions started back in May 2021. Staff member J stated it had all come to a head in October 2021, but at the time there was a vice president of the company that would neither let her report it nor would he let her in this building to investigate it. Staff member J stated she did complete an offsite audit with the pharmacy back in September and October of 2021. Staff member J stated there were definitely signs that NF1 was involved in the medication diversion. During an interview on 3/31/22 at 10:10 a.m., staff member A stated no audits were completed when NF1 was suspended for medication diversion.	F 610	on reportable incidents on or before 4/29/22. 4. Executive Director or designee will audit 5 facility reported incidents to validate a thorough investigation was completed and documented appropriately weekly x4 weeks, then monthly x 2 months. Audits will be brought to QAPI on or before 4/28/22 to identify trends and sustainability, then monthly thereafter. 5. 5/15/22	

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During an interview on 3/31/22 at 10:22 a.m., staff member B stated NF1 was suspended for her not reporting knowledge of a diversion, not the actual medication diversion. Staff member B stated they reported it because she was suspected, and she was working in the facility during the time of the investigation. Staff member B stated the previous administrator had not shared the real story and once he was gone the details came out. Staff member B stated they did not complete an audit and did not think there was a reason to ensure there was not medication diversion that occurred. Staff member B stated NF1 was transferred to this facility because of difficulties with other coworkers at the other facility.

Review of NF1's employee information, showed a start date of 10/1/21 to the facility, and a termination date of 12/6/21.

Review of a Complaint Form on NF1, dated 11/23/21, showed, "There is a suspicion that [Name] has been involved or noted as a suspect in multiple drug diversion investigations from May 2021, July 2021, October 2021, and November 2021.

Review of Pharmacy Audits, showed:

- On the report dated 9/27/21, there was no narcotic medications missing.
- On the report dated 10/21/21, there were missing pages from the narcotic ledgers for three residents, and 137 doses of medications were missing or considered as a potential theft for five residents.

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F 610	Continued From page 16 A request for Medication Audits related to the medication diversion for November 2021 were requested on 3/31/22. The requested documents were not provided by the facility. Review of the facility's Abuse Investigation policy, dated 9/2017, showed: - "Through investigation, the Center works to determine if the abuse, neglect, exploitation, and/or mistreatment has occurred and to determine the extent and cause... - 5. The Center maintains complete and thorough documentation of the investigation." Refer to F602 related to resident information and misappropriate of resident property.	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 ensure accuracy of the MDS, in which a resident's medication was coded as insulin, for 1 (#51) of 1 sampled resident. Findings include: During an interview on 3/30/22 at 9:53 a.m., staff member F stated resident #51 was on medications for her diabetes, but not insulin. During an interview on 3/30/22 at 10:16 a.m., staff member G stated she was responsible for signing off on the MDS assessments, and staff	F 641	1. MDS coordinator corrected the inaccurate MDS for resident #51 at the time of discovery during survey on 3/30/22. 2. MDS coordinator or designee looked back one quarter for residents on Trulicity and corrected any inaccurate MDS's at the time of discovery on or before 5/15/22. MDS Coordinator or designee will validate that other MDS's that were completed from 4/15/22 through 4/24/22 were accurate by 5/15/22.	5/15/22

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member H would have completed resident #51's MDS assessment. Staff member G stated resident #51 took Trulicity, and she would consider it an insulin because it was for a diabetic.

During an interview on 3/30/22 at 10:20 a.m., staff member H stated Dulagutide (Trulicity) was not a true insulin but since it was an injection, he believed it should be coded under insulin.

During an interview on 3/30/22 at 4:22 p.m., staff member G stated she emailed her corporate MDS resource, and she sent back that the medication was not a form of insulin. Staff member G stated she did education with the other MDS person. Staff member G and H planned to look back a quarter and correct all the MDSs that have Trulicity on them.

Review of resident #51's Order Summary Report, dated 3/30/22, showed, two medications related to a diagnosis of Type II diabetes mellitus with diabetic neuropathy, unspecified, Dulaglitude solution (Trulicity) 1.5 mg/0.5 ml subcutaneously one time every 7 days and metFORMIN HCL extended release 500 mg give two tablets twice a day. No insulin order was noted.

Review of staff member G's email from corporate, dated 3/30/22, showed: "How is Trulicity different from insulin? by drugs.com No, Trulicity is not a form of insulin. Trulicity mimics the effects of GLP-1 a naturally occurring hormone that stimulates insulin secretion..." [sic]

Review of resident #51's MDS, with an ARD of 3/8/22, under section N0350., showed, the resident recieved insulin.

F 641

3. Executive Director (RN) or designee re-educated MDS staff and IDT on the requirements of accurate MDS assessments on or before 4/29/22.
4. Executive Director or designee will review 5 MDS's to validate the MDS is accurate weekly x4 weeks, then monthly x2 months. Audits will be brought to QAPI on or before 4/28/22 to identify trends and sustainability, then monthly thereafter.
5. 5/15/22

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F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure repositioning for a dependent resident, which lead to skin breakdown and made the resident feel "helpless and lousy," for 1 (#51) of 1 sampled resident. Findings include: During an observation and interview, on 3/30/22 at 3:40 p.m., staff member E performed wound care and a dressing change to the sacrum and buttocks area on resident #51. An open wound, which looked to be 1 cm in size, was noted inferior to resident #51's sacrum. Staff member E stated, "That wasn't there yesterday, it was just a reddened area." During an interview on 3/29/22 at 9:18 a.m., resident #51 stated she had turned in a grievance for care not being provided to her. She stated she felt "helpless and lousy" because she cannot even turn herself over if they (staff) are not going to help her. During an interview on 3/30/22 at 3:28 p.m., staff member L stated resident #51's grievance was for not being repositioned. Staff member L stated she handed it over to the director of nursing, and the resolution was "care in pairs" which just always means two staff members. Staff member L stated staff would know because it is in resident #51's care plan and on the "report sheet." Staff	F 677	1. Resident #51 had turning and repositioning to her C.N.A care tasks at the time of discovery during survey on 3/31/22. 2. Executive Director or designee will validate other dependent residents have turning and repositioning with documentation on the C.N.A care tasks by 5/15/22. 3. Executive Director (RN) re-educated staff on the requirements of caring for dependent residents including repositioning and turning every 2 hours and documentation on or before 4/29/22. 4. Executive Director or designee will review 5 dependent care tasks to ensure turning and repositioning is being completed with documentation weekly x4 weeks, then monthly x2 months. Audits will be brought to QAPI on or before 4/28/22 to identify trends and sustainability, then monthly thereafter. 5. 5/15/22	5/15/22

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member L stated nursing management was responsible for ensuring the resident was repositioned.

During an interview on 3/30/22 at 3:36 p.m., staff member M stated resident #51 was cares in pairs for bathroom needs, but she was not sure how often staff were to reposition her.

During an interview on 3/30/22 at 3:54 p.m., staff member B stated he was not sure about the resolution of resident #51's grievance, he just knew she had one.

During an interview on 3/30/22 staff member A stated the facility did not have CNA repositioning or monitoring documentation for resident #51, so there was not a way to ensure it was being completed, but it was being added.

Review of resident #51's grievance, dated 3/7/22, showed:

- She was, "not getting repositioned every 2 hours, not getting 2 hour check and changes..." [sic]
- "Action taken: cares in pairs ... having staff keep notes of when/what was done with patient." [sic]

Review of resident #51's ADL care plan, dated 3/8/22, showed:

- "I require staff to perform cares in pairs."
- "At risk for skin: I have a pressure reducing W/C cushion."
- "At risk for skin: I have a pressure reducing mattress."
- "...I require mechanical lift with 2 assist to move between surfaces."

F 677 Continued From page 20 F 677

- "...I require one assist with my toileting."
- "...I require one assist with my dressing/undressing."
- "...I require one assist with my oral care."
- "...I require one assist with my personal hygiene."
- "...I require one assist with my showering/bathing."
- "...I require one assist with my dressing/undressing."
- "...I wear glasses assist me with my impaired visual acuity."
- "...I am able to eat meals with supervision."
- "Monitor/document/report prn any changes, any potential improvement, reasons for self-care deficit, expected course, declines in function."

Review of resident #51's Daily Skilled Evaluation, dated 3/30/22, showed:

- "A2. Has there been a change in condition since the last evaluation?" It was marked yes.
- "A2a. Describe the change in condition: open area on coccyx, and blister on upper right thigh."

Review of resident #51's Admission Evaluation, dated 3/2/22, showed no skin impairment to the coccyx area.

Review of resident #51's Weekly Skin Evaluation, showed:

- On 3/8/22, a first observation of a non-pressure wound to the right front iliac crest.
- On 3/15/22, a non-pressure ulcer to the right abdominal fold (Pannus fold) was unchanged.
- No wounds to the coccyx area were noted on her weekly skin evaluations.

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F 677	Continued From page 21 Resident #51's CNA Repositioning Documentation was requested on 3/31/22. No documentation was provided by the facility.	F 677		
F 689 SS=J	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 non-smoking facility, failed to thoroughly assess, monitor, supervise, and implement constructive interventions for a resident who was a non-compliant and unsafe smoker, for 1 (#36), and the resident had a history of smoking in the facility, on facility grounds, eloped while smoking or attempting to smoke, had a second degree facial burn from smoking in his room with his oxygen on in May 2021, refused to allow the facility to assist and secure his smoking materials (lighter, cigarettes, and matches). The facility neither had a safe designated smoking area, nor enforced the policy for smoking. These cumulative failures increased the imminent risk of injury for resident #36 and others residing at the facility; and the facility failed to ensure an effective system was in place for residents who eloped or were at risk of eloping, for 2 (#s 24 and 36) of 2 sampled residents, and the facility did not monitor, supervise, re-evaluate safety interventions when necessary, or	F 689	1. Resident #36 discharged on 4/8/22. Resident #36-smoking evaluation completed 3/30/22. IDT reviewed assessment and deemed safe to smoke with supervision on 3/30/22. Resident #36 will have supervised smoking in the TLC courtyard where there is a smoking blanket, cigarette buttress, and fire extinguisher; smoking items to remain locked in the nurses cart or med room; skin evaluation completed, will not wear oxygen when smoking; will not smoke in room; care plan updated to include elepement and smoking interventions/safety risks; a comprehensive smoking assessment, 1:1 supervision with storage of smoking items (lighter) and a current BIMS. ON 3/30/22, an order was obtained to allow the resident to leave the building on pass from the provider. New resident sign in/out sheet implemented for resident and	5/15/22

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implement ample safety interventions, for the residents.

On 3/29/22 at 4:49 p.m., the facility Administrator was notified that an Immediate Jeopardy existed in the area of F689: Free of Accident Hazards /supervision/devices, for smoking.

The severity and Scope identified for the Immediate Jeopardy was identified to be at the level of J, and upon removal of immediacy, lowered to a G.

Findings include:

A. Smoking and Elopement

During an observation on 3/29/22 at 7:50 a.m., resident #36 was observed on the sidewalk with his four wheeled walker, smoking. Resident #36 proceeded to walk through the front doors of the facility, enter the code to unlock the second set of entrance doors, and returned to his room in the skilled nursing facility.

During an observation on 3/29/22 at 8:07 a.m., resident #36 did not check in with staff at the front desk when reentering the building after smoking, and did not secure his smoking materials with the staff.

During an observation and interview on 3/29/22 at 9:26 a.m., resident #36 was walking back into the building, wearing thin clothes, and it was heavily sleeting outside. He stated he had gone for a smoke, and during the interview stated he had no intention of stopping smoking. He stated he kept his smoking materials on his person, and he had "hidy holes" all over his room at the facility.

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responsible party to go out to smoke and for outings to include resident□s destination, 1:1 staff signature, nurse signature, date and time, resident signature and confirmation of returning smoking paraphernalia to nursing staff to secure. 1:1 visual supervision will be in place for duration of his stat at all times until discharged from the facility. If the resident is non0complian with the plan in place, progressive action will take place up to notice of discharge to ensure all residents safety. Designated smoking times will be 7a, 11a, 3p, 7p, and 11p. 3/30/22, with assigned staff member. Nurse to give resident #36 his lighter when he goes out to smoke. 1:1 will ensure the nurse receives the lighter back. 1:1 to ensure resident takes oxygen off prior to going out to smoke. Smoking evaluations to be completed quarterly or with change of condition. Skin assessments are completed weekly and PRN with new skin concerns. Therapy completed a MOCHA on 3/30/22 with no concerns noted. Executive Director to oversee the smoking policy and compliance with the smoking policy. Resident #24-Director of Nursing or designee will update the care plan to include the root cause of elopement and interventions to decrease risk of elopement on or before 5/15/22.
2. Other residents were at risk due to resident #36 smoking non-compliance. No other residents identified to have smoking paraphernalia or to be smoking in the facility 3/30/22. Director of Nursing or designee will validate other residents

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During an interview on 3/29/22 at 2:00 p.m., staff members A and B stated, the facility was non-smoking, but resident #36 attempted to smoke. Resident #36 was cognitive enough to be educated and he had no need of skilled nursing services. He was still at the facility until his disability kicked in in February. His goal was to live in an apartment. Resident #36 used oxygen, but facility staff were not sure how much he actually used it anymore, other than possibly to sleep. He did not take the oxygen with him outside. The facility told him he could not smoke and then he eloped by pushing the window screen out, climbing out the window, and walking to the store for beer and cigarettes. Resident #36 would sign himself out to smoke off property. This was the intervention after he was caught smoking in his room and burning himself. Resident #36 kept his smoking supplies on his person or in a lock box provided but this was not verified as he did not let anyone in his room.

During an interview on 3/29/22 at 2:05 p.m., staff member S stated "Yes," resident #36 smoked. Staff member S had not had any training related to the facility smoking policy, resident #36's smoking or sign out process, and was not aware of any prior smoking injuries of resident #36.

During an interview on 3/29/22 at 2:07 p.m., staff member R stated "Yes," resident #36 smoked. He would go out to the sidewalk past the parking lot. He signed out and then back in when he was done, and he had his cigarettes and matches. The facility policy was the residents had to be off the property (if smoking). Staff member R stated he was not trained on the smoking policy and not aware of any prior smoking injuries of resident

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that are at risk for elopement have updated care plans to include interventions to decrease the risk of elopement on or before 5/15/22.
3. Vice President of Clinical Operations for Empres educated Divisional Director of Clinical Operations (DDCO) on Empres Resident Smoking Safety Policy and Abuse, Neglect, or Exploitation Policy regarding resident safety on 3/29/22. DDCO educated Director of Nursing and Executive Director on Empres Resident Smoking Safety Policy and Abuse, Neglect, or Exploitation Policy regarding resident safety 3/29/22. Director of Nursing educated the nurse management team on Empres Resident Smoking Safety Policy and Abuse, Neglect, or Exploitation Policy regarding resident safety on 3/29/22. All staff will be educated on Empres Resident Smoking Safety Policy and Abuse, Neglect, or Exploitation Policy regarding resident safety prior to their next schedule shift. Staff that worked the evening and night shift were educated on 3/29/22. Residents were educated on 3/30/22 on the smoking policy. Education was provided to staff on shift for evenings and oncoming night shift 3/29/22 and 3/30/22 regarding the 1:1 being able to visualize resident when in room and will be 24 hour supervision until resident #36 becomes compliant with the storage of lighter with the nurses storing them in the med cart. SDC initiated education 1:1�s on being able to visualize resident at all times, supervise smoking, and to remain the resident, to report any concerns of

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#36. Staff member R stated, "I believe he's safe if management is letting him [smoke]."

During an interview on 3/29/22 at 2:10 p.m., staff member E stated resident #36 smoked off the property. Staff member E stated resident #36's smoking routine consisted of him telling us he was going out to smoke, alone. His supplies were in a lock box in his room. The nurse manager and resident #36 had a key. The policy was the facility was non-smoking. Staff member E stated there was no training for staff related to resident smokers but she had been trained at another facility. She stated resident #36 had an injury about a year ago, and he was sneaking out of his room and got burned when smoking. Staff member E stated if they [management] were allowing him to smoke, he was deemed safe. Staff member E stated there were weekly skin assessments for resident #36, and there had been no issues.

During an observation on 3/30/22 at 11:36 a.m., resident #36 was smoking across the street from the front of the facility, by himself, without a smoking blanket, fire extinguisher, and not in the designated smoking area. A staff member was standing on the corner of the parking lot watching resident #36 from down and across the street.

During an observation on 3/30/22 at 1:49 p.m., staff member C, asked where resident #36 was. The assigned staff member, who was the designated 1:1 for the resident, was staff member Q. Staff member Q was observed feeding another resident in the dining room. Staff member Q told staff member C resident #36 left in his truck at 1:30 p.m. When he left, there was a time set for smoking, so he got upset and left. Staff

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non-compliance to supervisor immediately. Education initiated on 3/30/22 on the revised sign in/out sheet to staff and resident #36. Executive Director and DDCO re-educated resident verbally on 3/29/22 on risk to other and is documented in PCC. Resident #36 refused to sign anything. Agency staff and new staff will be educated on resident #36�s smoking plan prior to start of their first scheduled shift. New staff and agency staff will be trained on fire safety/procedure prior to their 1st scheduled shift. Executive Director or designee will re-educate staff on elopement policy and following interventions for residents that are at risk for eloping on or before 4/29/22. Facility reviewed the non-smoking policy wiht no revsions necessary on or befoer 4/29/22.
4. Executive Director will review smoking compliance 5 times per week during clinical meeting. Any non-compliance noted during clinical meeting will be reviewed with IDT to determine the course of action needed. Executive Director to report results to QAPI monthly. QAPI was held on 3/30/22 to address the plan for removal of the immediacy of the IJ. Since resident #36 discharged, the Executive Director or designee will review 5 residents to validate there are no concerns with smoking in the facility or storage of smoking paraphernalia weekly x4, then monthly x3. Executive Director or designee will review 5 residents that are at risk for eloping to validate their care plans include interventions to decrease the risk of elopement and 5 staff

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F 689	Continued From page 25 member Q was unsure of where resident #36 went. Staff member C asked if she notified anyone, and she stated she told staff member F. During an observation on 3/30/22 at 2:00 p.m., resident #36 was not in his room. The room was wall to wall belongings with a clear path out to the door. The bed was pushed against the wall and below the window. The room smelled heavily of old cigarette smoke. At the nurses station resident #36's sign out book showed the last sign out time as 1:30 p.m., but the sign out sheet did not have the correct date documented, or a return time. During an observation on 3/30/22 at 2:01 p.m., staff member Q was sent to the lobby by staff member F to wait for 1:1 supervision of resident #36. During an interview and observation on 3/30/22 at 2:02 p.m., staff member C was asked for the sign out for resident #36, since he had not returned to the facility. The form with check-in/out times was not dated accurately, so it was unclear if the documented time was accurate. During an interview on 3/30/22 at 2:04 p.m., staff member F stated resident #36 usually started smoking early in the day. Even before staff member F got to work in the mornings. Staff member F stated this, while he was trying to decipher when the times on the sign-out sheet started, for the current day. The date was not listed on the sign out sheet/binder. Staff member F signed the sign out sheet for the 1:30 p.m. sign-out of resident #36, even though that was the only nurse initials on any sign out sheet in the binder, and not when the resident actually signed	F 689	members to validate the staff know the proper response for an elopement weekly x4, then monthly x2. Audits will be brought to QAPI on or before 4/28/22 to identify trends and sustainability, then monthly thereafter. 5. 5/15/22	

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out.

During an interview on 3/30/22 at 2:06 p.m., staff member T stated resident #36 had the door code for the front door of the facility, so he would just walk in and out. Normally residents and visitors would check in with her when entering and exiting the building. The last time she saw resident #36 was when she was arriving to work in the parking lot. Resident #36 was out smoking, and a staff member was standing away from him, observing him. She had not seen him come through the front door of the facility, otherwise, but she wasn't always manning the door. The only other exits were the assisted living door, or the staff entrance where the staff smoked, which was at the back of the facility.

During an interview on 3/30/22 at 2:13 p.m., staff member A stated resident #36 just got in his truck and left the facility grounds.

During an interview on 3/30/22 at 2:29 p.m., staff member Q stated, she was told when she arrived on her shift she would be resident #36's 1:1. She was to sit in $36's room with him, and go with him on the property. She was not told what area was designated for his smoking, any specific times for smoking, or if anything needed to be documented. Staff member Q stated resident #36 had left the building around 12:40 p.m., and he did not say where he was going. Resident #36 seemed upset with a talk management had about smoking rules. Staff member Q was to sit at the front door and wait until resident #36 arrived back to continue the 1:1 assignment. Staff member Q stated she would stand at the sidewalk on the facility property, as the resident smoked across the street. He would continue to smoke until he

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re-crossed the street and tossed the butts on the property before walking back in the facility. Staff member Q stated resident #36 had smoked since he was admitted, and when he was newer, he had gotten burned smoking in his room.

During an interview on 3/30/22 at 3:41 p.m., staff member T stated resident #36 got back to the facility, "an hour ago."

Review of resident #36's current physician orders did not show any order for resident #36 to leave the facility on his own.

Review of resident #36's nursing progress notes showed:

- 5/29/21 Noted burn on lip and nose.
- 5/30/21 Resident admitted to smoking. Forgot to take off oxygen canula and had been smoking in his room in the facility. Resident sent to ER and returned on 5/31/22 with treatments for 2nd degree burns on his face.
- 6/4/21 Resident #36 eloped through his room window to go get cigarettes when under 15 minutes checks.
- 6/5/21 Resident told a CNA to steal cigarettes for him.
- 6/7/21 Resident met with the Executive Director, stated he would act like a prisoner because that was how he was treated for smoking in his room out the window. Resident was hanging out of his window to smoke.
- 6/15/21 Executive Director said he can go on supervised walks and could not smoke nor could staff accompany him to smoke.
- 6/24/21 Resident room smelled of smoke and his head was out the window.
- 6/27/21 Popped screen off his window again.

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- 6/29/21-6/30/21 Resident put a fan in his window.
- 8/4/21 Resident smoking in room.
- 8/9/21 Resident smoking in room.
-11/21/21 Resident found outside the front door of the facility smoking. Resident was given non-smoking reminder by a staff member.
- 12/16/21 Resident reported "boo boos on blister" on his thumb and scrapes on leg that were the same size and shape. Resident stated he got them when his truck caught on fire, and he slid off the hood.
- 12/22/21 Filled his room with boxes of belongings.
- 3/1/22 Care conference with the the facility staff and resident stated his room was a fire hazard.
- 3/5/22 Resident came in from smoking with low oxygen saturation.

Review of resident #36's smoking evaluations, dated 3/23/22 and 6/2/21, showed a lack of conclusion for the resident's risk and intervention needs related to safely smoking.

Review of resident #36's MOCA assessment showed a score of 23/30. A normal score was equal to or greater than 26/30. This assessment is designed to show cognitive functioning including: orientation, visiospacial awareness, memory, attention, and executive functioning of a person's brain.

Review of resident #36's assessment lists from 3/1/21- 3/23/22 showed weekly skin assessments were not completed every week.

Review of resident #36's Care Plan, last updated 11/29/21, showed:

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- For smoking, there was a problem area added on 5/30/21 showing, "Resident is an active smoker, has been caught smoking in the building." The goal was last updated on 11/29/21 as, "Resident will not bring smoking materials into building, will not smoke here, especially while on oxygen therapy." The interventions were last updated 6/8/21 as, "Nursing has offered getting provider to order patch or other safe nicotine therapy. Resident declines nicotine therapy" and "Resident has stated he will no longer smoke in his room."
-For the elopement problem area added on 6/8/21, the plan showed, "The resident is an elopement risk/wanderer crawls out window r/t impaired safety awareness." Under interventions the care plan showed, "Assess for fall risk. Frequent checks daily." No other updates or interventions were in place related to the resident leaving the building and property for smoking or without alerting staff.

Review of resident assessments showed on 6/4/21 a "pre-elopement" and "at elopement" assessments were completed. No other elopement risk assessments were conducted during resident #36's admission or added to the care plan.

Review of the facility policy, Resident Smoking Safety, updated 8/2019, showed:

- Smoking is only done supervised, and not allowed in the building.
- "Appropriate interventions are care planned and implemented based on the results of the Smoking Safety Evaluation.
- If a resident wants to smoke independently off grounds, the Center does not knowingly allow this

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to occur without supervision.
a. Smoking materials are provided to residents for/during center supervised smoking only. If a resident requests to go on LOA and requests smoking materials, the Center declines the request. The resident, if able, may purchase their own smoking materials while off grounds but must relinquish them upon return to the Center.
- A portable Fire Extinguisher, rated Class A, is stored in the designated smoking area.
- A fire blanket is stored in the designated smoking area.
- Ashtrays of non-combustible material and safe design shall be provided in all smoking areas...
-Metal containers with self closing cover devices shall be readily available in all smoking areas...
-Residents who smoke remain at least 25 feet away from oxygen in use.
-Residents who use oxygen are instructed to remove the mask or cannula, shut off the oxygen supply, and wait for the oxygen to dissipate for a minimum of five minutes prior to smoking.
-When there is potential or identified conflict between the residents right to smoke and/or the residents continued smoking while using oxygen and/or the risk of harm to self or others, a re-evaluation of the residents smoking is completed. Residents safety outweighs the residents right to smoke."

B. Elopement

During an interview on 3/30/22 at 9:54 a.m., NF3, stated resident #24 had an elopement recently. He had a very tough deal and spends most of his time in his room. His pain management was poor and it increased his behaviors.

During an interview on 3/30/22 at 2:11 p.m., staff

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member T stated, she was new and had not been a part of a drill for elopement or missing residents. She had online training modules that went over elopement during orientation. The facility had a few residents with wanderguard bracelets, and the doors to the skilled nursing and assisted living entrances were alarmed if a resident wearing a bracelet would get within range.

During an interview on 3/30/22 at 2:39 p.m., staff member Q stated, there were residents who wander and some had wanderguard bracelets on. Nurses checked the bracelets to ensure they were working and for the placement. There was a resident who eloped recently, but she was not working when it happened. If a resident was an elopement risk it would have been on the care plan, and staff would try to redirect or use interventions for a resident exit seeking, or start a missing resident search if they couldn't find a resident.

During an interview on 3/31/22 at 9:20 a.m., staff member B stated, resident #24 eloped the month before, in February 2022. He was wearing a wanderguard and had gone through the assisted living doors. A neighboring building resident noticed resident #24 in their parking lot and walked him back to the skilled nursing facility entrance. Staff member B stated resident #24 was not harmed upon assessment, and the responsible party and physician notifications were done including a progress note for the incident. Resident #24 had dementia and would wander aimlessly through the halls. When anxious and agitated he would exit seek, usually looking for his friend or son, both with the same name. Staff were to redirect and offer snacks as he needed

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the calories since his disease process was declining.

Review of a facility reported incident for resident #24's elopement showed, the event happened on 2/15/22 at 6:20 p.m., resident was seen wandering the halls in his wheelchair by nursing an undetermined amount of time prior to being returned to the facility front doors by a neighboring facility resident.

Review of resident #24's care plan showed for elopement:

- The problem area, "[Resident #24] is an elopement risk/wanderer attempting to find car and go to bank r/t History of attempts to leave facility unattended. Resident wanders aimlessly." This was initiated on 11/11/20 and revised on 3/3/21. Interventions initiated on 11/11/20 and revised on 11/18/21 were, "Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers:" and "WANDER ALERT: walker/wheelchair #F04F1D right ankle # Model" [sic]

- Another problem area added on 2/21/22 showed: "[Resident #24] has an actual elopement R/T Alzheimer's DISEASE, UNSPECIFIED, UNSPECIFIED DEMENTIA WITH BEHAVIORAL DISTURBANCE." The interventions were entered on 2/21/22 and showed, "Check on me frequently during the day when I am up in my wheelchair" and "Distract me from wandering by offering pleasant diversions, structured activities, food, conversation, television, book" [sic] The Care Plan did not address the root cause of how resident #24 eloped from the facility.

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Review of resident #24's progress notes showed:

- 2/16/22 "At approx. 1810h [6:10 p.m.], this nurse was given report that a staff member answered the front door to view an unknown person from [neighboring facility] accompanying res. Was told that the resident was found in the [neighboring facility] parking lot next door and brought back. He was dressed in a shirt, blue jeans, socks and shoes, sitting in his w/c. 'I went outside, I don't know why ... I knew it was wrong.' Physical assessments yielded no skin redness/trauma. Res is poor historian and unable to explain how or why he left the building or even who assisted in returning him to the facility. Res was last seen propelling self in his w/c in the hallways of the SNF when the nurse was on her rounds. A CNA reported that she heard the ALF alarm sounding and as she was occupied in the restroom, she was unable to reset the alarm 'after about 5 mins'. She reported that no one was observed in the hallway leading into the ALF unit. Wanderguard in place around right ankle. Tested positively for alarm and is in active mode."
The responsible party and on-call provider were notified.
- 2/17/22 "Residents wonder guard is on his left ankle, he continues to circle the halls from timbers to tlc occasionally checking doors at the end of the halls. I have had to go get him 6 times on assisted living on my shift, he sets the alarms off, I redirected him back to out unit ..." [sic]
- 3/22/22 "Resident open the door at the end of hall 3, and began to exit, redirected resident." [sic]

F 758 SS=E Free from Unnec Psychotropic Meds/PRN Use
CFR(s): 483.45(c)(3)(e)(1)-(5)
F 758 — 5/15/22

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§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:
(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

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F 758	Continued From page 35 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 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to follow the order requirements for continuing PRN psychotropic medications for 1 (#24) of 2 sampled residents, and failed to conduct timely GDRs for 2 (#s 42 and 48) of 3 sampled residents. This had the potential to affect the resident's health and wellbeing. Findings include: 1. During an interview on 3/31/22 at 10:10 a.m., staff member A stated there was no GDR for Seroquel for resident #48. A review of resident #48's monthly MAR's from 5/1/21 to 3/30/22 showed: an order start date for "SEROquel Tablet 25 MG, give 0.5 tablet by mouth one time a day" [sic] of 11/14/20. Additionally, the monthly MAR's from 5/1/21 to 3/30/22 showed a daily administration of Seroquel. A review of resident #48's monthly MAR's from 5/1/21 to 7/31/21 showed: an order start date of 8/21/20, for "Zoloft Tablet 25 MG (Sertraline HCl) Give 50 mg by mouth one time a day". Additionally, the monthly MAR's from 5/1/21 to 8/23/21 showed a daily administration of 50 mg of Zoloft.	F 758	1. Director of Nursing or designee will validate that resident #48 has a GDR request completed for Seroquel and Zoloft; resident #42 has a GDR request completed for Celexa; and resident #24 will have a 14 day stop date for Ativan and ABH gel on or before 5/15/22. 2. Director of Nursing or designee will validate other residents on psychotropic medications have had an attempted GDR if necessary and PRN psychotropic medications have 14 day stop dates on or before 5/15/22. 3. Executive Director or designee re-educated the IDT on the requirements of GDR's and 14 day stop dates on psychotropic medications on or before 4/29/22. 4. Executive Director or designee will review 5 residents on psychotropic medications to validate a GDR has been attempted as needed and a 14 day stop date for PRN psychotropic medications weekly x4, then monthly x2. Audits will be brought to QAPI on or before 4/28/22 to identify trends and sustainability, then monthly thereafter. 5. 5/15/22	

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A review of resident #48's monthly MAR's from 8/1/2021 to 3/30/22 showed: an order start date of 8/24/21, for "Zoloft Tablet 25 MG (Sertraline HCl) Give 75 mg by mouth one time a day". Additionally, the monthly MAR's from 8/24/21 to 3/31/22 showed a daily administration of 75 mg of Zoloft

2. A review of resident #42's monthly MAR's from 6/1/21 to 2/18/22 showed: an order start date of 6/10/21, for "CeleXA Tablet 10 mg by mouth one time a day" [sic]. Additionally, the monthly MAR's from 6/10/21 to 2/18/22 showed a daily administration of 10 mg of Celexa.

A review of a facility document titled, "Note To Attending Physician/Prescriber" for resident #42, dated 7/1/21, showed: "Please review the current antidepressant therapy and provide an appropriate diagnosis for use for the following medication(s): citalopram 10 mg daily for UNSPECIFIED DEMENTIA WITHOUT BEHAVIORAL DISTURBANCE." The "agree" box was checked and signed with an illegible signature.

A request for an additional Celexa GDR for resident #42 was submitted on 3/30/22 at 10:23 a.m., and staff member A stated they did not have any other Celexa GDRs for resident #42.

A review of the facility policy titled, "Policy: Psychotropic Drugs", with a updated date of January 2019, showed:

- ..."7. Gradual Dose Reductions (GDR) Guidelines
    a. Gradual dose reductions consist of

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tapering the resident's daily dose to determine if the resident's symptoms can be controlled by a lower dose or to determine if the dose can be eliminated altogether.

b. Residents taking a psychotropic medication, unless contraindicated, undergo a gradual dose reduction.

i. If psychotropic initiated within the last year, attempt GDR in two separate quarters with at least one month between attempts.

ii. If more than one year, attempt GDR annually, unless contraindicated." ...

2. During an interview on 3/31/22 at 9:30 a.m., staff member B stated, resident #24 had PRN Ativan and ABH gel. The Ativan was more widely used, and the ABH gel was only in circumstances when the resident would not calm down after using the Ativan. The gel would work when administered. Staff member B stated resident #24 had the prns for his dementia behaviors and being on hospice. He was under the impression that as long as the doctor provided a reasoning after the initial 14 day psychotropic order they could continue with the prn. He did not realize the psychotropics always needed a stop date for prns.

Review of resident #24's current physician's orders showed an order:

-"ABH 1/25/1 Gel: Apply 1ML topically every 6 hours prn for agitation." There was a current order start date of 1/7/22 with no stop date.
-"Lorazepam Tablet 0.5 MG Give 0.5 mg by mouth every 4 hours as needed for Prophylaxis related to Alzheimer's Disease, unspecified." Current order start date of 2/18/22 with no stop

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F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		4/29/22

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to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure their unvaccinated staff for COVID-19 were following the additional personal protective equipment requirements while working in the facility. And facility staff failed to perform hand hygiene while administering medications for 4 (#s 1, 18, 34, and 36) of 4 sampled residents. This practice has the

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DIRECTED PLAN OF CORRECTION

This Directed Plan of Correction is required by the Centers for Medicare and Medicaid, and the Montana State Office of Inspector General, Certification Bureau, related to the identification of deficient practice for F880 - Infection Control, cited

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potential to affect all residents residing in the facility. Findings include:

1. During an interview on 3/30/22 at 1:55 p.m., staff member F stated the additional personal protective equipment for non-vaccinated staff members was an N95 and a face shield.

During an observation and interview, on 3/30/22 at 9:53 a.m., staff member F was working on the medication cart, and was not wearing additional eye protection. He stated, he does not normally work as the floor nurse.

During an observation on 3/30/22 at 1:41 p.m., staff member F was not wearing additional eye protection.

During an interview on 3/30/22 at 2:12 p.m., staff member O stated she had not been vaccinated and forgot to wear her eye protection that day.

During an interview on 3/30/22 at 2:20 p.m., staff member K stated the personal protective equipment, if you have not been vaccinated, should be a N95 mask and eye wear. Staff member K stated glasses do not count as additional eye protection because it had to go around the sides of your eyes.

During an observation and interview, on 3/30/22 at 2:28 p.m., staff member N was calling bingo with her N95 mask completely tucked under her chin, with her eye goggles on, and a resident sitting at the table with her. Staff member N stated, "Guess I will just scream so the residents can hear me call this," in regard to wearing her mask while calling bingo.

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at the Severity and Scope of F. Corrections are to be completed by the date noted in Criteria Five - the Date of Completion/Compliance (X5 date). At a minimum, the facility will carry out and complete the following plan:

a. The facility administrative IDT team, to include the Administrator, DON, and Infection Preventionist, will:

Use a root cause analysis process to review and assess the deficient practices identified on Form CMS-2567. The goal will be to identify areas of needed improvement, and then the team will work to develop a plan and implement a plan for the correction. The failures included:

· Failure to ensure proper personal protective equipment (PPE) was used, and used correctly, when needed; and,
· Staff failed to sanitize hands properly during the provision of medications and going from resident to resident.

b. The facility DON or Designee will medically assess those residents noted in F880, to include #s 1, 18, 34, and 36, and attempt to determine if the residents had any negative outcomes related to staff failure to properly use PPE and sanitize hands as necessary.
The assessments will be documented in the individual resident EHR's.

2. Criteria Two: Identification of Others

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Review of the facility's COVID-19 Vaccine Exemption/Accommodation Response Form, showed, "Describe specific accommodation details: When working in Centers- 2x weekly Covid testing. N95 and Eye protection must be worn at all times..."

Review of the facility COVID-19 Staff Vaccination Status for Providers showed:

- Staff member F was granted an exemption.
- Staff member N was granted an exemption.
- Staff member O was granted an exemption.

2. During an observation on 3/30/22 at 11:51 a.m., staff member D failed to sanitize her hands after completing medication administration for resident #1 and then proceeded to pour medications for resident #18.

During an observation on 3/30/22 at 12:03 p.m., staff member D failed to sanitize her hands after picking up four dropped pills from the floor in resident #18's room. She then discarded the dropped pills, and proceeded to dispense the replacement medications for resident #18 from the medication cards into a new medication cup.

During an observation on 3/30/22 at 12:07 p.m., staff member D failed to sanitize her hands after completing medication administration for resident #18 and then proceeded to pour medications for resident #34.

During an observation on 03/30/22 at 12:11 p.m., staff member D failed to sanitize her hands after completing medication administration for resident #34 and then proceeded to pour medications for resident #36.

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The Administrator, DON, and Infection Preventionist will:

Comprehensively review infections/trends over the last 6 months, using current infection control standards of practice, for the identification of other residents affected or potentially affected. Data taken from the review will be used to for the identification, planning, and implementation of corrective measures for any residents identified as affected. The review and outcome will be documented thoroughly and made available for review during the revisit survey.

3. Criteria Three: Systems

a. The facility administrative IDT team, to include the Administrator, DON, and Infection Preventionist, will:

Use a root cause analysis process to review and assess the deficient practices identified on Form CMS-2567. The goal will be to identify areas of needed improvement, and then the team will work to develop a plan and implement a plan for the correction. The failures included:

Failure to ensure proper personal protective equipment (PPE) was used, and used correctly, when needed; and, Staff failed to sanitize hands properly during the provision of medications and going from resident to resident.

b. The IP will review the current infection control monitoring and surveillance

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During an interview on 3/30/22 at 3:35 p.m., staff member D stated staff member F oriented me on medication administration, hand hygiene was taught, "wash in, wash out, which I already knew."

Review of a facility document titled, Medication Administration, Quick Reference Guide, with a updated date of June 2017, showed, "... 12. The nurse washes his/her hands between residents or uses approved hand-sanitizer between residents. The nurse washes his/her hands every three to five residents or if soiled, between each resident." ...

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program and processes to ensure the program is providing adequate monitoring and surveillance of staff related to the prevention of infections. This will specifically include monitoring for medication pass infection control procedures, and use of PPE by staff.

c. The Facility Administrator and Director of Nursing will identify specific employees or departments in need of ongoing education for the areas of deficient practice and infection control. Once staff are identified, training will be planned and carried out by the date noted in Criteria Five. At a minimum, education must include:

- Correct use of PPE, when to use it, how to use it, why it is used.
- Infection control procedures during medication pass.

Criteria Four: Monitoring

a. The IP will review current facility infection control monitoring and surveillance program and processes to ensure the program is including the use of PPE by staff, and infection control during medication pass. The goal will be to identify or implement a long-term monitoring system for the deficient practices.

b. The Administrator, DON, and IP, will develop a short-term monitoring plan for the direct observations of staff using PPE correctly, and that they are adhering to

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infection control practices during medication pass or going room to room. At a minimum, direct observations will be completed at least 6 times each week for one month, and as needed. Any concerns identified related to the failure to adhere to infection control practices will be addressed immediately through education or corrective action, and documented. Trends noted will be addressed by the team in a timely manner. Findings of the observations will e presented and discussed with the QAPI team.

c. The QAPI team will have ad-hoc meetings weekly for one month for the review steps taken to carry out this plan, and work to resolve quality deficient practices related to it, prior to further issues occurring. The goal will be to ensure a system is established that will be "sustained."

d. The QAPI committee will review all corrections completed for this deficiency, on or prior to 4/28/22, and verify all corrections are complete and compliance has been achieved. This review and determination will be documented in a manner in which it may be reviewed by the State Survey Agency for the determination of compliance.

Criteria Five: Date of Completion/Compliance 4/29/22

1. Resident #34, #18, and #36 no longer resident at the facility. Resident #1 will be

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F 880	Continued From page 44	F 880	reviewed by the IDT to evaluate if resident #1 had any negative outcomes due to improver PPE use and improper had sanitation on or before 4/29/22. 2. Other residents had to potential to be affected by improper PPE use and improper hand sanitation. Director of Nursing or designee will review other residents to determine if any adverse outcomes were identified on or before 4/29/22. A 6 month review of infections and trends will be completed by Infection Preventionist on or before 4/29/22. 3. IDT will use a root cause analysis process to review and assess the deficient practices of improper PPE use and improper hand sanitation on or before 4/26/22. The IDT reviewed the current infection control monitoring and surveillance to determine if the monitoring needs to occur more often. Monitoring will include PPE use and hand hygiene during med pass. Executive Director (RN) or designee re-educated staff including nursing and activities on PPE use and hand hygiene on or before 4/26/22. Staff members D, F, and N have been identified and will be re-educated on PPE use and hand hygiene on or before 4/26/22 or next scheduled shift. 4. Executive Director or designee will audit 5 nurses or medication aides to validate proper hand hygiene and 5 staff to validate proper PPE use 6 times per week for 4 weeks, then 3 times per week for 4 weeks, then weekly for 4 weeks, then monthly x2 months. Audits will be brought to QAPI on or before 4/28/22 to identify trends and sustainability, then	

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