STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075438	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Uncasville	5 Richard Brown Drive Uncasville, CT 06382

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47402 Based on review of facility documentation, review of policy and interviews, the facility failed to notify the Long-Term Care Ombudsman's office of discharges and transfers within a timely manner. The findings include: Review of the facility's long-term care Ombudsman notification report for the month of September 2023 identified there were eleven residents discharged and/or transferred from the facility. The report identified that the notifications were sent to the Ombudsman's office on 10/6/23 (one day late). Review of the facility's long-term care Ombudsman notification report for the month of October 2023 identified there were twelve residents discharged and/or transferred from the facility. The report identified that the notifications were sent to the Ombudsman's office on 3/11/24 (six days late). Review of the facility's long-term care Ombudsman notification report for the month of November 2023 identified there were twenty-six residents discharged and/or transferred from the facility. The report identified that the notifications were sent to the Ombudsman's office on 1/26/24 (fifty-two days late). Review of the facility's long-term care Ombudsman notification report for the month of January 2024 identified there were sixteen residents discharged and/or transferred from the facility. The report identified that the notifications were sent to the Ombudsman's office on 3/11/24 (thirty-five days late). Review of the facility's long-term care Ombudsman notification report for the month of February 2024 identified there were twenty-six residents discharged and/or transferred from the facility. The report identified that the notifications were sent to the Ombudsman's office on 3/11/24 (six days late). Interview with Social Worker #1 on 3/14/24 at 11:30 AM identified she was responsible for sending the notifications of the resident discharges and transfers to the Ombudsman office. She further noted that the notifications should be made by the 5th of the following month for the previous month. Social Worker #1 further identified that the late notification were due to an oversight on her part. (continued on next page)

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

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F 0623 Level of Harm - Potential for minimal harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the policy entitled State Long Term Care Ombudsman Transfer/Discharge report identified that all facility-initiated discharges including medical leaves of absence when the resident is expected to return, voluntary discharges to home, and voluntary transfers to another skilled nursing facility are required to be included in the monthly discharge notification. The policy further identified that for any other types of facility-initiated discharges, the facility must provide notice of discharge to the resident and resident representative along with a copy of the notice to the State Long-term care ombudsman 30 days prior to the discharge. The director of social services is responsible for running the monthly report at the beginning of each month.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of facility documentation review of facility policy and interviews for one sampled resident (Resident #286) who had an indwelling urethral catheter, the facility failed to develop a comprehensive care plan to address the specific type of catheter, how often the catheter should be changed, the size of the balloon to be used with the catheter, and the general care of the catheter as it relates to the resident. The findings included: Resident #286 was admitted to the facility on [DATE]. Resident diagnoses included Type II diabetes mellitus with diabetic polyneuropathy, above the knee right side amputation, neuromuscular dysfunction of the bladder, and renal dialysis. The quarterly Minimum data set (MDS) assessment dated [DATE] identified Resident #286 had intact cognitive status, had an indwelling Foley catheter, and was dependent on staff for mobility, transfers, and personal care. The care plan dated 3/6/2024 identified Resident #286 required staff assistance with activities of daily living, wore glasses, was morbidly obese, and utilized a wheelchair for mobility. The care plan further identified the resident had an indwelling urinary catheter in place but further review of the care plan failed to include the size of the indwelling catheter, instructions on how often the catheter should be changed and/or irrigated, or instructions on when the bag itself should be switched to a leg bag. Review of the monthly physician's orders for March/2024 failed to identify orders that addressed the use of the indwelling urethral catheter and/or the care of the catheter. Interview with the DNS on 3/14/2024 at 2:34 PM identified that the expectation for care planning would be to provide specific details to direct use and care of the indwelling Foley catheter. She further noted that orders and care planning can come from hospital discharge recommendations but should be specific to the resident's needs and noted that the initial care plan is completed by the admission nurse or the MDS coordinator on admission. Interview with the MDS coordinator on 3/14/2024 at 11:55 AM identified the care plans are reviewed at the resident's quarterly meetings. The admission nurse would be responsible for the initial care plan, depending on when the resident was admitted . Review of the facility Care Planning Policy dated 10/30/2020 identified the facility will develop a comprehensive and individualized plan of care will be developed for each resident to guide caregivers to assist residents to achieve or maintain their highest practical level of well-being. The care plan will include reasonable and measurable goals and interventions to achieve these goals and discipline responsible for carrying out the interventions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on observation, clinical record review, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #236) with a recent history of smoking, the facility failed to administer a nicotine patch for a newly admitted resident. The findings include: Resident #236 diagnoses included cellulitis of left leg, cellulitis of right leg, Type 2 diabetes mellitus with diabetic chronic kidney disease, and tobacco use. The admission Minimum Data Set assessment dated [DATE] identified Resident #236 had intact cognition, required extensive assistance with bed mobility, and was independent to eat. The Resident Care Plan dated 3/11/24 identified prior to admission Resident #236 was actively smoking in the community. Interventions directed to offer to obtain a MD order for nicotine patch, nicotine gym or nicotine lozenges. A physician's order dated 3/9/24 directed to apply NicoDerm CQ 24hr 21mg 1 patch transdermal one time a day for and remove per schedule. Interview with Resident #236 on 3/10/24 at 11:30 AM identified he/she was not given a nicotine patch because they did not have any available. He/She was a pack and a half a day smoker prior to admission and needed a nicotine patch to help curb his/her cravings. Progress Note from LPN #1 on 3/10/24 at 3:12 PM identified Resident #236 was non-compliant with care and was in a lot of pain. When trying to re-approach stated I need oxy and patch when Tylenol was given it was taken by mouth the cup was crumpled and thrown to the floor. Interview with LPN #1 on 3/12/24 at 11:24 AM identified she did not pass the Nicoderm patch on Sunday 3/10/24 due to the fact there were none in stock. Interview with RN#2 on 3/13/24 10:07AM identified she was responsible for the admission of Resident #236 on 3/9/24. She identified she did not administer a nicotine patch as she did not have any on hand. She looked on all of the carts and in the back stock room and none were available. RN#2 identified the weekends are difficult when you are out of a supply like this because the deliveries come in on Mondays. Interview with DON on 3/13/24 at 9:30 AM identified there were two boxes of 14mg Nicotine patches and two boxes of 7 mg Nicotine patches that were ordered on 3/8/24 and arrived in the facility on 3/11/24. Review of medication cart identified that no patches were available on Saturday, Sunday, and part of Monday in the facility. At least one box of each should always be kept on hand and orders are put in on Fridays by the nurse scheduler and received on Mondays. The DON identified if medication is not available it should be ordered stat from the pharmacy which should be delivered in 4 hours, however pharmacy does not usually deliver NicoDerm Patches as a stat medication. No documentation was received that this medication was in fact ordered stat on 3/9/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of purchase order #OGV195240 created on 3/4/24 delivery date 3/11/24 identified two boxes of 14 mg Nicotine Patch was ordered and two boxes of 7mg Nicotine Patch was ordered. Interview with Resident #236 on 3/12/24 at 2:50 PM identified his/her significant other brought 21mg Nicotine patches to the facility Monday 3/11/24 afternoon prior to going to work, and that was the first time one was applied. Documentation of a patch applied by the facility in March 2024 Medication administration record did not occur until 3/12/24 at 8:21 PM. Review of the Omnicare policy 5.2 Receipt of Interim/Stat/Emergency delivered policy revised 1/1/22 directed facility should immediately notify Pharmacy when Facility receives from a Physician/Prescriber a medication order that may require an interim/stat/emergency delivery. If a necessary medication is not contained within Facility's interim/stat/emergency supply, and Facility determines that an interim/stat/emergency supply is necessary, Facility should arrange with Pharmacy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on observations, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #286) reviewed for accidents, The facility failed to ensure that the resident was transferred safely via mechanical lift. The findings include: Resident #286's diagnoses included type II diabetes mellitus with diabetic polyneuropathy, above the knee right side amputation, neuromuscular dysfunction of the bladder, morbidly obese and renal dialysis. The Nursing Admission assessment dated [DATE] identified Resident #286 required a total mechanical lift transfer with the assistance of two staff. The quarterly Minimum data set (MDS) assessment dated [DATE] identified Resident #286 had intact cognition, was dependent on staff for mobility, transfers, and personal care and had an indwelling urinary catheter in place. Review of the social services quarterly assessment dated [DATE] identified Resident #286 utilized a mechanical lift and an electric wheelchair for mobility. The care plan dated 3/6/2024 identified Resident #286 required staff assistance with activities of daily living with an intervention to transfer per MD orders. The resident care card identified Resident #286 was a fall risk and required the assistance of two staff with mechanical lift transfers. The care card did not specify which mechanical lift (the facility has a bariatric lift) and/or pad to use when transferring the resident. Interview on 3/10/24 at 2:51 PM with Resident #286 identified that he sustained a fall from the mechanical lift while being transferred from the wheelchair to the bed during which he/she was dropped a hit his back on the side rail of his/her the bed. He further noted that he requested to be sent to the hospital. Review of hospital emergency room visit notes dated 1/12/24 identified Resident #236 identified that he/she was dropped onto the side rail while being transferred in the mechanical lift and complained of severe pain. The note further identified that the resident had been given a CT scan, which showed a small disc protrusion at the lumbar 5 and sacral 1 spine with unremarkable soft tissues. The doctor noted tenderness present in the lumbar back with no swelling and decreased range of motion. Impression of the CT scan identified probable disc bulges/herniations with limited detail due to resident's obesity. Recommendation made to consider further assessment with an MRI. The Reportable Event Report dated 1/13/2024 identified Resident #286 reported the same events as noted in the emergency room visit notes. The report further identified the mechanical lift was in working order and there two nurse aides present during the transfer. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with NA #6 on 3/11/24 at 1:25 PM identified that she worked 2nd shift on 1/12/24 and assisted another NA with Resident #286's transfer from the wheelchair to the bed via mechanical lift (Reliant 450 Hoyer). NA#6 further identified that when the other NA went to move the mechanical lift, it tipped to the right and the wheels on the left were completely off of the ground. NA #6 noted that she was holding the straps on the mechanical lift pad and identified that the wheel base was not in the expanded position. She further noted that Resident #286 fell on to the bed and complained of back pain at that time. NA#6 identified that she immediately notified the charge nurse, she also noted that she worked until 9:00 PM and did not see anyone go in to speak with Resident #286 prior to the end of her shift. Interview with RN #4 on 3/12/2024 at 2:20 PM identified she was the nursing supervisor for the 2nd and 3rd shifts on 1/12/24-1/13/2024. She identified Resident #286 returned from dialysis between 8:30 and 9:00 PM on 1/12/24 and she was notified close to 11:00 PM that Resident #286 wanted to go to the hospital to be evaluated after being dropped during a mechanical lift transfer. She identified that the nurses' aides denied dropping the resident. Further, RN #4 notified the on call APRN and obtained an order for a one-time dose of Dilaudid 2mg, which the resident refused. RN #4 identified that she asked to assess the resident's back where the pain was located, and the resident was in too much pain to move. RN#4 identified Resident #286 refused to be assessed. RN #4 further identified that she failed to document the resident's refusal. In addition, review of the clinical record lacked documentation of the incident, lacked information as to how the incident occurred and lacked documentation of injuries sustained as a result of the incident. Interview with the DNS on 3/14/2024 at 2:34 PM identified the expectation for the Hoyer use would be to be specific to direct use and outlined on the care plan. Review of the facility Transfer Methods policy dated 12/2008 identified Rehab will assist nursing in the determination of the appropriate mechanical lift and that nursing will train their staff on the use of the appropriate lift. Review of the facility's Mechanical Lift policy identified that nursing personnel will use the mechanical lift as directed per physician's order. Number 12 of the procedure identified to open the base of lift to the widest position (chassis legs). Number 15 of the procedure identified the chassis legs may be closed during movement only if attempting to maneuver in an area with limited space such as doorway, bathroom, etc. Review of the Manufacturer's Recommendations for the Reliant 450 and 600 Hoyer lifts identified manufacturer recommendations for lifting preparation included a black box warning that directed: Before lifting or transferring the patient, the base legs MUST be LOCKED in the OPEN position for optimum stability and safety. The manufacturer's specifications identified the Reliant 450 had a weight capacity of 450 pounds. The facility failed to ensure that the mechanical lift was operated per manufacturer's recommendations and per facility policy with ensuring that the mechanical lift base is opened to the widest position to provide the maximum stability when transferring a resident. Resident #286 weighed upwards of 429 pounds, making it necessary to ensure the legs were in the open and locked position in order to stabilize the lift and ensure it did not tip over during the transfer.

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402 Based on clinical record review, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #236) reviewed for pain, the facility failed to administer pain medication for a resident whose pain level was assessed at a severe level of pain. The findings include: Resident #236's diagnoses included cellulitis of left leg, cellulitis of right leg, Type 2 diabetes mellitus with diabetic chronic kidney disease. The care plan dated 3/9/24 identified Resident #236 was at risk for pain/discomfort and noted that pain may impact mobility, mood (anxiety, depression), behaviors, sleep, ADL functioning, and relationships with others. Care plan interventions directed medication(s) as ordered, skilled assessment of pain symptoms: location, type, duration, frequency, intensity, factors that exacerbate and relieve pain. Admission physician's orders dated 3/9/24 directed to assess pain every shift using the pain of scale 010 0: no pain 1-2: mild pain 3-4: minimal pain 5-6: moderate pain 7-8: strong pain 9-10: severe pain, and administer Oxycodone HCl oral tablet 15 mg, give 1 tablet by mouth every 3 hours as needed for severe pain. The admission history and physical progress note dated 3/10/24 authored by MD#1 identified Resident #236 was admitted to the facility on [DATE] status post peritoneal dialysis catheter placement, lower extremity cellulitis with chronic wounds with a plan to continue Oxycodone (narcotic) and return to the pain clinic when stable where previously on Suboxone (opioid). Observation on 3/10/24 at 11:30 AM identified Resident #236 lying in bed crying, interview with Resident #236 at the time of the observation identified he/she had been administered a dose of Oxycodone early that morning. He/she further identified that he/she had been admitted to the facility around 9 or 9:30 PM on 3/9/24. In addition, Resident #236 identified he/she was in severe pain at the present time and noted that the nurse was aware that he/she was experiencing severe pain. Interview with LPN #1 on 3/10/24 at 11:40 AM identified she was aware that Resident #236 was in pain, and noted she was waiting for the resident's pain medication to be delivered from the pharmacy. The nurse's note dated 3/10/24 at 3:12 PM written by LPN #1 identified Resident #236 was in a lot of pain and non-compliant with care. When attempts made to re-approach, resident identified that she needed Oxycodone and a Nicotine patch. The note further identified that when the resident was administered Tylenol, the cup was crumpled and thrown to the floor. Further review of the nurse's note failed to identify the resident was administered Oxycodone by LPN #1 at any time during the shift. The Nurse Practitioner's (#1) progress note dated 3/11/24 identified Resident #236 had undergone multiple vascular procedures in the most recent hospital stay including lower extremity angioplasties with stent placements and peritoneal dialysis catheter placement on 3/1/24. The note further identified that the resident's hospital stay was complicated by uncontrolled pain which required intravenous (IV) opioids. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A second interview with LPN #1 on 3/12/24 at 11:24 AM identified she entered Resident #236's room around 10:00 AM to administer morning medications, and Resident #236 complained of pain and rated it as a level 10 on the pain scale. She noted that she did not administer Oxycodone for the resident's complaint of severe pain because the medication had not been delivered by the pharmacy. She further identified that she did not think to check the automated medication dispensing system because she thought that it contained back up medications for residents that already had their medications in house. Additionally, LPN#1 identified that medication was retrieved from the automated medication dispensing system for Resident #236 because the therapist went into the room to see the resident and identified that the medication could be obtained from the automated medication dispensing system. She further noted that she and the Therapist went to the Nursing Supervisor, who was able to obtain the Oxycodone HCL 15mg dose from the automated medication dispensing system, but LPN #1 could not recall administering the medication to the resident, and identified that her shift ended shortly after 3:00 PM Review of the medication administration record (MAR) for 3/10/24 identified Resident #236 had been administered Oxycodone HCL 15mg at 5:25 AM and then at approximately 5:00 PM but failed to reflect documentation that Oxycodone HCl was administered between 7:00 AM and 3:00 PM (1st shift). Further review of the MAR identified Resident #236's pain level was assessed at a level 10 (severe) on the 1st shift. Interview with the Nursing Supervisor (RN#5) on 3/12/24 at 11:48 AM with LPN #1 present, identified she was notified by the MDS Coordinator (RN #3) on 3/10/24 in the afternoon that Resident #236 was in pain and needed to be medicated with medication from the automated medication dispensing system (emergency medication storage). RN#5 further noted that she obtained the medication from the automated medication dispensing system and handed it to LPN #1. Review of the automated medication dispensing system's detail report with the DNS on 3/12/24 at 11:58 AM identified RN #5 retrieved Oxycodone 10mg at 2:08 PM and Oxycodone 5mg at 2:09 PM on 3/10/24 from the automated medication dispensing system (emergency medication supply). Interview with the MDS Coordinator (RN #3) on 3/12/24 at 12:12 PM identified that she went to Resident #236's room to convey the date of the care plan meeting, and while in the room she identified the resident was in severe pain and notified LPN #1. RN #3 further noted that LPN#1 told her that the resident did not have any available Oxycodone because the resident's medications had not yet been delivered by the pharmacy. RN #3 noted that she told LPN #1 that she could obtain the Oxycodone from the automated medication dispensing system and went with LPN #1 to speak with RN #5. Further, RN #3 identified that she accompanied RN #5 to the automated medication dispensing system to obtain the medication and then watched RN #5 hand the medication to LPN #1. RN #3 further identified that the medication should have been documented in the electronic MAR, which would indicate the time the medication was administered. After reviewing the MAR for 3/10/24, RN #3 identified that she did not see documentation to indicate the resident was medicated with Oxycodone on first shift. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A third interview with LPN #1 on 3/12/24 at 12:20 PM identified she could not locate documentation of the administration of Oxycodone on 3/10/24, however she indicated that it was a crazy day, and she may have forgotten to document. LPN#1 indicated that she may have thought she did not have to document administration due to the fact the medication was not from her cart and that it was obtained from the automated medication dispensing system and indicated that she thought the administration may have been documented already through the automated medication dispensing system. LPN#1 indicated she did not notify the Nursing Supervisor when the medication was unavailable and the resident's pain level was at a level 10. A second interview with Resident #236 on 3/12/24 at 2:45 PM identified that on 3/10/24 she was in pain all day and she needed a Nicotine patch that he/she had his/her significant other on standby waiting for him/her to say the word for him/her to come pick him/her up. Resident #236 further noted that she was not medicated for pain until sometime on the second shift and identified that they wanted to change the dressings on his/her legs immediately after administering the medication but he/she told the nurse that he/she needed to wait until the pain medication kicked in first. He/she did not know the exact time he/she was medicated but referred to a text message that had been sent to his/her significant other at 5:02 PM that identified that they'd just given him/her medication. Resident #236 indicated that it was around that time that he/she had finally received the medication. Further, he/she noted that she had not received pain medication on the first shift on 3/10/24. Interview with MD #1 on 3/14/24 at 11:45 AM identified she saw Resident #236 on 3/10/24 around 8:00 AM and the resident did not complain of pain at that time. and noted was not notified the resident was in pain on 3/10/24 following her visit to the facility. MD #1 further identified that she would expect to be notified if a resident is in pain and a pain medication is unavailable or ineffective at controlling the pain. Interview with the Staff Development nurse (RN #6) on 3/12/24 at 2:40 PM identified training materials regarding medication administration are done via video as well as verbal information about various topics. She further identified LPN #1 was walked through the automated medication dispensing system area during the orientation tour and also received 120 hours of mentoring for orientation. Review of the Receipt of Interim/Stat/Emergency delivered medications policy identified that the facility should not borrow medication from another resident. The facility should immediately notify the pharmacy when the facility receives from a physician/prescriber a medication order that may require an interim/stat/emergency delivery and if a necessary medication is not contained within a facility's interim/stat/emergency supply, and the facility determines that an interim/stat/emergency supply is necessary, the facility should make arrangements with the pharmacy to obtain the medication. Based on review of the facility's policy, interviews and record review, the facility failed to comply with their policy for obtaining a necessary medication in a timely manner. The facility failed to ensure that a resident who was assessed to be in severe pain and had pain medication ordered for severe pain that could be administered every three hours was medicated as ordered. The resident waited for a period of approximately 9 to be medicated for complaints of severe pain.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some Note: The nursing home is disputing this citation.	Observe each nurse aide's job performance and give regular training. 48335 Based on review of facility documentation, review of facility policy, and interviews for three nurse aides (NA #1, 2, & 3) and failed to complete the background check for LPN #5, the facility failed to complete annual performance reviews. The findings include: Review of the employees' files for NA #1 hired on 7/20/17, NA #2 hired on 8/15/19, and NA #3 hired on 9/07/12, failed to contain annual performance reviews for 2023. Interview on 3/13/24 at 2:36 PM with the Human Resources Director (HRD) identified the performance reviews for NA #1, NA #2, and NA #3 were not completed and the background check for LPN #5 was not found. The HRD identified that she would check with the company who provided the background check, and have one completed and further noted that she keeps the newest registry for the NAs in a binder in her office and the Staff Development Nurse keeps track of the Licenses for nurses. A second interview on 3/14/24 at 9:34 AM with the Human Resources Director identified that performance reviews are completed annually around the anniversary of the employee's hire date. She further identified that there was a change in Human Resources (HR) and the Director of Nursing Service (DNS) positions last year and noted that she started on April 13th, 2023. Review of the Performance and Review policy directed, in part, that a formal and documented performance review should occur at the end of the employee's introductory period and will occur at least annually thereafter.

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	075438	A. Building B. Wing	03/14/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335 Based on observations, review of facility policy, and interviews for one medication storage room and two medication carts reviewed, the facility failed to properly discard a controlled medication by its expiration date. The findings included: Observation on [DATE] at 1:38 PM of the first floor, side 1 and side 2 Medication storage room refrigerator identified Lorazepam oral liquid 2mg/ml for resident #19 with an opened date of [DATE], and a discard date of [DATE]. Interview on [DATE] at 1:57 PM with LPN #2 (first floor side 1 medication nurse) identified she was not sure why the oral Lorazepam was still in the refrigerator and noted that once it is opened it is dated and can remain on the cart for 30 days unrefrigerated, or if it's in the refrigerator once opened, it's good for 90 days. She further identified that she would call the ADNS to pick it up. Interview on [DATE] at 2:22 PM with the DNS identified that the staff call if a medication is expired, and she goes around weekly to see if they have any narcotics or medications that have expired and need to be destroyed. She further identified that she keeps a destruction log and destroys as needed and has no set schedule for destruction. Review of the Storage and Expiration Dating of Medication, Biologics policy dated [DATE] directed, in part, that the facility should destroy or return all discontinued, outdated or expired, or deteriorated medications in accordance with pharmacy return/destruction guidelines and other applicable laws.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. 17723 Based on review of facility documentation, review of facility policies, and interviews, the facility failed to review the infection prevention control program policies and procedures at least annually, failed to provide documentation that the Infection Control Surveillance and Safety rounds were conducted on a quarterly basis, and failed to provide documentation that monthly infection reports or analysis of infection trends within the facility were completed, along with quarterly reports in 2022 and 2023 . The findings include: 1. Review of the facility's Infection Control Program Policies and Procedure manual for the past two years with the DNS (former IP and currently oversees the IP program) on 3/12/24 at 12:19 PM identified that the policies and procedures manual was reviewed on 7/18/23, and 1/1/24, but failed to provide any documentation that the Infection Control Program Policies and Procedure manual was reviewed in 2022. Interview with the DNS on 3/12/24 at 12:19 PM identified that the policy and procedures manual should be reviewed annually, and it's the responsibility of the then IP nurse to ensure that it was completed. The DNS further added that she was not working at the facility during the time for the annual review was due, as she started working as the IP in July of 2023 until December of 2023. Review of the Infection Prevention and Control Program policy directed that an annual review to be conducted of the Infection Prevention and Control Program and to update the program as necessary to include updates as national standards changes. 2. Review of the Infection Control Surveillance and Safety rounds documentation for the past two years with the DNS (former IP and currently oversees the IP program) on 3/12/24 at 12:19 PM identified that the quarterly infection control surveillance and safety rounds were not completed for the months of April 2022, July 2022, October of 2022, January 2023, and April 2023. Interview with the DNS on 3/12/24 at 12:19 PM identified that she was unable to locate the quarterly infection control surveillance and safety rounds forms for the months of April 2022, July 2022, October of 2022, January 2023, and April 2023. The DNS further added that she started working at the facility in July of 2023 and it would have been the responsibility of the previous IP nurse to ensure that the infection control surveillance and safety rounds were completed. Review of the Infection Control Surveillance and Safety Rounds policy identified that Surveillance rounds are conducted on a quarterly basis by the Infection Preventionist. The policy further identified that rounds will be documented on the surveillance rounds form and maintained by the Infection Preventionist. 3. Review of the infection control program for the past two years with the DNS (former IP and currently oversees the IP program) on 3/12/24 at 12:19 PM failed to identify that monthly infection reports or analysis of infection trends were completed for the year of 2022, and during the period of January 2023 to June 2023, along with the quarterly reports for January of 2022, April 2022, July 2022, October 2022, January 2023, April 2023, and July 2023. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Medical Staff Meeting agendas for all the quarters in 2022 and 2023, the documentation provided failed to identify any topics related to infection control. Interview with the DNS on 3/12/24 at 12:19 PM identified she was not working at the facility during the time frame and was unable to locate the reports. The DNS indicated that she would continue to search for the reports prior to her started date in July of 2023. The DNS further added that she was unable to locate the quarterly infection control reports in the Medical Staff Meeting binder, only the ones she completed. Interview with the DNS on 3/14/24 at 11:00 AM identified that she was able to locate the infection control individual reports for residents for the year 2022 but was able to find the monthly report/analysis that consisted of the rate of healthcare/facility acquired infections and community acquired infections within the facility. Review of the Monthly Infection Report policy identified that the monthly infection report is completed in the first week of each month for the month prior to compute rates of nosocomial (Healthcare/Facility) and community acquired infections and resolution rates. The policy further identified that the records would be maintained for a period of no less than three years. Review of the Surveillance Data Collection policy identified that an infection surveillance data collection form would be completed for each resident with an infection. The policy further identified that the data collected would be analyzed monthly for treads and incorporated into the quarterly infection control report. Review of the Quarterly Infection Report policy identified that the Infection Control Nurse (Infection Preventionist) completes the quarterly report quarterly and presented data collected to the infection control committee for review/recommendation.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Implement a program that monitors antibiotic use. 47900 Based on review of facility documentation, review of facility policy and interviews, the facility failed to ensure that a review of the antibiotic stewardship program including antibiotic usage, and audit tool results were presented at the quarterly medical staff meetings. The findings include: Review of the antibiotic stewardship program for the past two years with the DNS former IP and currently oversees the IP program) on 3/12/24 at 12:19 PM failed to identify any documentation related to monthly review of the antibiotic stewardship program for the period of January 2023 to June 2023. The facility also failed to provide documentation that a quarterly review of antibiotic usage for 2022 and 2023 was presented at the quarterly medical staff meeting. A review of the Review of the Medical Staff Meeting agendas for all the quarters in 2022 and 2023, the documentation provided by the facility failed to identify any topics related to infection control and antibiotic usage/antibiotic stewardship program within the facility that was presented at the Medical Staff Meeting by the Infection Preventionist. Interview with the DNS on 3/14/24 at 11:00 AM identified that she was not working at the facility during the time frame and was only able to locate the monthly Antibiotic Tracking tool for 2022. The DNS further added that she reviewed the Medical Staff Meeting binder and was unable to locate any reports that included the antibiotic stewardship program that was presented at the quarterly medical staff meeting that was held in 2022, 2023, and was only able to locate the reports that she completed for the last quarters in 2023. The DNS further added that started the role of the facility's Infection Preventionist (IP) in July of 2023 to December of 2023, and it would have been the responsibility of the previous IP to complete and present the reports at the quarterly medial staff meeting. Review of the Antibiotic Stewardship policy identified that all infections will be tracked by the IP or designee and reviewed for trends. The policy further directed that the facility would review the antibiotic usage and present findings quarterly at the medical staff meeting. Review of the Infection Prevention and Control Program Manual Surveillance policy identified that data analysis is completed by the IP from both process and outcomes of surveillance activities, which this data is recorded at least quarterly.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 47900 Based on facility documentation, review of facility policy, and interviews the facility failed to have a consistent designated Infection Preventionist (IP) with the required specialized training in infection control, that was responsible for the facility's Infection Control Program in 2022 and 2023. The findings include: Interview with the DNS on 3/12/24 at 12:19 PM identified that she was the Infection Preventionist at the facility starting in July of 2023 until December of 2023. The DNS further added that her role was changed to DNS on December 22, 2023, and that she currently oversees the program until the newly hired nurse for the Infection Preventionist position completes the required specialize training. Interview with Human Resources on 3/13/24 at 10:19AM identified and provided a total of 3 nurses who worked in the position of an IP prior to the DNS in the years of 2022 and 2023. Human Resources identified RN #8 with a date of hire of 5/16/23 and termed on 5/26/23, RN #9 with a date of hire of 12/6/21 and termed on 4/25/2022, and RN #10 with a date of hire of 7/19/22 and termed on 8/14/22. Human Resources identified that RN #12 worked mainly as the wound nurse for the facility from 12/7/22 to 6/28/23 but did not work in the month of March 2023 based on her employee punch history. Interview with the Cooperate Nurse RN #11 on 3/13/24 at 12:50 PM identified that they had staff filling in the role as the IP such as RN #12 who was in the role as the IP for the facility, but there was a gap in the facility in the years 2022 and 2023 with having a designated IP. A request was made on 3/14/23 at 10:00 AM to Human Resources for any certification or specialized training related to infection control for all the individuals hired for the IP role. Although requested, Human Resources failed to provide a copy of the employees who were hired as IP in the years of 2022 to 2023. Review of the facility's Infection Prevention and Control Program identified that the facility would designate one or more individual (s) as the infection control preventionist and had completed specialized training in infection prevention and control.