Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6001697	A. BUILDING: ________ B. WING ________	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGO RIDGE SNF	**10602 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415**

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S 000	Initial Comments Complaint Investigation 2398780 / IL165761	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	S9999		

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resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

These requirements are not met as evidenced by:

Based on interview and record review, the facility failed to provide adequate supervision, assistive devices and proper transfer technique to prevent a fall of 1 (R1) of 3 residents reviewed for accident/hazards in the sample. This failure resulted in R1 being emergently transferred to the hospital after a mechanical fall during transfer from bed to chair causing excruciating pain and femoral fracture.

Findings include:

R1 is a 71 year old resident with diagnosis of spinal stenosis, lack of coordination, heart failure, end stage renal disease, absence of left leg above knee amputation, absence of right leg below knee amputation, and femur fracture.

MDS (Minimum Data Set) dated 11/1/2023 assessed resident's ability to perform chair/bed-to-chair transfer and states, "The ability to transfer to and from a bed to a chair (or wheelchair). Not attempted due to medical

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condition or safety concern."

Records showed:

On 10/18/23 at 1:14 PM V27 (LPN/Licensed Practical Nurse) wrote, "Patient being sent to hospital for x-rays to rule out possible injury for right hip/leg that occurred during transfer from bed to specialty chair." Calls to interview V27 went unanswered and V27 is no longer an employee of the facility.

V2 (Director of Nursing) interview with V11 (CNA/Certified Nurse's Aide) "Spoke to (V11) and she stated she transferred (R1) with a bear hug. The resident was complaining of pain prior to transfer. She stated R1 did not hit her leg on the chair nor bed."

Efforts to contact V11 (CNA) on 1/3/24 and 1/4/24 were left unanswered and V11 is no longer an employee of the facility.

Care plan dated 10/13/23 states, "Resident is at risk for falls related to falls. Goal: Will have no serious fall related injury through next review. Interventions: Be sure call light is within reach and encourage the resident to use it for assistance as needed. Staff to respond promptly to all requests for assistance. Anticipate and meet individual needs of the resident. Complete the Fall Risk Review per the facility protocol."

A facility fall protocol policy was requested but was never provided during the course of the survey.

R1's fall risk assessment dated 10/12/23 assessed by V31 (LPN) showed R1 to be a moderate risk for falls.

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On 1/8/24 at 11:30 AM, V3 (Assistant Director of Nurses) stated, "I remember this resident, but she was not here long. She was being transferred by this CNA (V11) and this CNA wasn't here long either. She was being transferred from bed to chair to get to dialysis and I think she may have fallen but I'm not sure how she got the fracture." Surveyor asked how this resident should have been assisted from bed to chair, V3 stated that the resident required a mechanical lift, "so the way this aide transferred her was inappropriate to transfer resident in a bear hug method."

On 10/18/23 at 12:20, V33 (Nurse Practitioner) noted, "Nurse approached writer stating patient was being transferred from bed to wheelchair to go to dialysis when patient stated she heard a "pop" in her right hip and patient screaming in excruciating pain. Patient seen reclined in geriatric chair and crying in pain "I heard a pop in my hip, I know it ' s broken". Upon palpation, right hip deformity noted, unclear if patient position in wheelchair/ or due to injury. Initially stat x-ray ordered of right hip, but radiology could not give a timeframe of when x-ray would be completed. Order given to send patient to hospital for further assessment."

On 10/19/23 at 8:20 PM, V34 (RN) noted, "Writer called hospital; resident to be admitted with diagnosis of femoral fracture, hepatic lesion, and pleural effusion."

Hospital records dated 10/18/23 authored by V72 (Emergency Department Doctor) reads, "This is a 71 year old female patient on Eliquis (blood thinner), congestive heart failure with preserved ejection fraction, COPD on home oxygen 3 liters, hyperlipidemia, prior stroke, peripheral artery

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disease status post right BKA (Below the knee amputation) and left AKA (Above the Knee Amputation) presents to the emergency department today from dialysis center for severe pain and deformity of her right thigh. Patient in excruciating pain so it is somewhat difficult to get the full story of what happened. Apparently, she was being transferred from 1 bed to the dialysis when her right leg was injured. There was immediate deformity of the right femur and pain over the site with tenting of the skin. Patient denies change in temperature or color or paresthesia of the limb distal to the deformity. Patient ultimately was reduced at bedside with orthopedic surgery. Patient received pain dosages of ketamine and fentanyl and tolerated the procedure decently well. Vascular surgery consulted and will follow inpatient but no indication for heparinization at this time. Social work consult placed to assess for safety at nursing home given severe injury with unclear mechanism. Discussed with hospitalist for admission."

Surveyor asked facility for policies related to the safe transfer of residents from bed to chair and was provided an ADL (activities of daily living) policy that reads, "Activities of daily living (ADLS) reads in part, "Transfers (standing pivot). Apply gait belt per plan of care, position resident to assist with further transfer. Place hands correctly (Do not hold under the arms) Provide cues to resident to let them know what you are doing. Assist resident to stand, using appropriate body mechanics. Pivot resident to the chair or bed, then lower slowly asking them to reach back for the chair."

(A)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	INITIAL COMMENTS Complaint Investigation 2398598 / IL165536- F725 2398713 / IL165672- F725 2398780 / IL165761- F689, F725 2398930 / IL165933- F602, F725, F755 2399005 / IL166035- F725 2399086 / IL166143- F602, F725 2399263 / IL166388- F602, F755 2399387 / IL166555- F725 2399493 / IL166678- F602, F684, F725 2399541 / IL166739- F602, F684, F725 2399625 / IL166839- F725, F880 2399692 / IL166928- F725, F880 23910107/ IL167427-F725 23910703/ IL168131- No deficiency 2490003 / IL168284- No deficiency Facility Reported Incident (FRI) Investigation FRI of 11-05-2023/ IL166931- F600	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600		1/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 01/25/2024

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 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility failed to follow their abuse policy and procedures by not ensuring a care plan was implemented for a resident when they were initially observed engaging in verbally and physically aggressive behaviors. This failure applies to two of four residents (R11 and R12) reviewed for abuse. Findings include: Final Abuse Investigation Report dated 11/05/2023 documents on 11/05/2023 R12 reported that she and her roommate R11 were involved in a verbal disagreement and R11 threw a cup of liquid on her. R11 denied throwing the liquid on R12 and both residents were hospitalized for psychiatric evaluation. R11's progress note dated 9/15/2023 documents she was observed presenting agitation with verbal aggression with obscene language. R11 was counseled on presenting social and verbal appropriate behavior. Resident was not receptive. Writer counseled the resident on presenting social and verbal appropriate behavior. R11's progress note dated 9/23/2023 documents she was observed hitting another resident in the face. Per R11 she was in hallway and resident walked past and she called her a profane name and R11 hit her in the face. R11 was separated from peer and put on one-to-one monitoring. Police report filed.	F 600	Submission of this Plan of Correction by Chicago Ridge SNF is not a legal admission that a deficiency exists or that this State of Deficiencies was correctly cited. In addition, preparation, and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. SS= D F600 Free from Abuse and Neglect(s): 483.12(a)(1) Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice. " R11 and R12 no longer reside at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.	

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F 600	Continued From page 2 R11's progress note dated 11/5/2023 documents she threw liquids in roommates face, R11 Immediately separated put on one-to-one monitoring and as needed medication was administered. Physician was notified and an order to send R11 to Local Hospital for evaluation was provided. On 01/08/2024 at 12:28 PM V1 (Administrator) stated he is the abuse coordinator. V1 stated if a resident has known behaviors of aggression the facility tries to address it by care planning to address the behavior. V1 stated if residents are aggressive towards staff, it is possible, they would be aggressive towards other residents. On 01/08/2024 from 1:08 PM - 1:55 PM V8 (Social Service Worker) stated before R11 became physically aggressive with R12 she had a few incidents of aggression. R11's current care plan documents an abuse care plan was not initiated until 11/07/2023 and a care plan for aggressive behavior was not initiated until 12/01/2023. The facility's Abuse Policy reviewed 01/09/2024 states: "The facility desires to prevent abuse. This will be accomplished by a comprehensive quality management approach. Through the care planning process, staff will identify and problems, goals, and approaches, which would reduce the chances of abuse."	F 600	" The Social Service Department (including identified V#□s) has been in-serviced on following the facility abuse policy and procedures by ensuring a care plan is implemented for residents when they are initially observed engaging in verbal and physically aggressive behaviors. " A weekly audit is being completed by the Social Service Director on 5 residents per week to ensure a care plan is implemented for residents when they initially engage in verbal or physically aggressive behaviors. Quality Assurance plans to monitor facility performance to make sure that the corrections are achieved and are permanent: " A QAPI tool was initiated by the Social Service Director on 5 residents per week to ensure a care plan is implemented for residents when they initially engage in verbal or physically aggressive behaviors. " Results of the weekly audits will be analyzed through the monthly Quality Assurance and Performance Improvement Committee (QAPI). The Administrator and Medical Director will monitor the process. The Committee will determine if the audits continue after three months.	
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12	F 602		1/23/24

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F 602	Continued From page 3 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 observations, interviews, and record reviews, the facility failed to prevent the misappropriation and/or diversion of medications for two (R2, R17) of three residents reviewed for medication administration; and failed to follow their facility's ordering and receiving of medications policy. This failure resulted in R2's pain medication (ibuprofen) being reordered in excess with minimal documentation of medication being administered to R2; and failed to have both resident's (R2, R17) personal medication supply readily available upon request for administration on numerous occasions. Findings include: 1. R2's electronic medical record indicated resident is a 66 year old male who admitted to facility on 11/07/2022 and has a past medical history not limited to: dementia with behavioral disturbance, hypertensive heart disease, anemia, polyneuropathy, cellulitis of bilateral lower extremities, peripheral vascular disease, glaucoma, and atherosclerosis. On 01/02/2024 at 2:11 PM, R2 stated that one to two months ago, he had asked for his ibuprofen 800mg and saw that he had a full card of this medication available but a few days later, when he asked for another pill, he was told that he	F 602	SS= D F602 Free from Misappropriation/Exploitation CFR(s):483.12 Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice. " R2 and R17 are residing safely in the facility. Their medications have been ordered and are readily available for receipt upon request. How the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. " The Facility Staff Nurses (including identified V#□s) were in-serviced on preventing misappropriation and/or	

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F 602	Continued From page 4 didn't have any tablets left on his card and staff would have to reorder this medication. R2 added that he had asked for an ibuprofen 800mg several times over the last few weeks but doesn't seem to have any of his own supply available and is given the facilities (house stock) medication. R2 then said that he can't understand why his personal medication supply is being reordered so frequently when he himself doesn't take this medication that often. R2's active physician orders includes but not limited to: one ibuprofen 800 milligram (mg) tablet by mouth every twenty-four hours as needed for severe pain rated between five-eight. R2's electronic medication administration records (MAR) indicated the following regarding his ibuprofen 800mg medication: January 2023 MAR indicated resident received this medication one time, February 2023 MAR indicated resident received this medication five times, March 2023 MAR indicated resident received this medication two times, April 2023 MAR indicated resident received this medication one time, May 2023 MAR indicated resident received this medication three times, June 2023 MAR indicated resident received this medication four times, July 2023 MAR indicated resident received this medication three times, August 2023 MAR indicated resident received this medication three times, September 2023 MAR indicated resident received this medication five times, and from October 2023 through current, it is not documented that resident was administered this medication during this time period. R2's pharmacy medication audit log dated 01/10/2023 showed resident's ibuprofen 800mg	F 602	diversion of medication, following the facility policy and procedure on ordering and receiving medication with an emphasis on ensuring residents' pain medication (ibuprofen) is available upon request. " A weekly audit is being completed by the Director of Nursing and/or designee on 5 residents per week to make certain misappropriation and /or diversion of medication is prevented, and the facility policy and procedures on ordering and receiving medication are being followed by making certain resident's pain medications (ibuprofen) is available upon request. Quality Assurance plans to monitor facility performance to make sure that the corrections are achieved and are permanent: " A QAPI tool was initiated by the Director of Nursing and/or designee on 5 residents per week to make certain misappropriation and /or diversion of medication is prevented, and the facility policy and procedures on ordering and receiving medication are being followed by making certain resident's pain medications (ibuprofen) is available upon request. " Results of the weekly audits will be analyzed through the monthly Quality Assurance and Performance Improvement Committee (QAPI). The Administrator and Medical Director will monitor the process. The Committee will determine if the audits continue after three months.	

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was reordered in March, April, May, June, August, September, and October of 2023 and again in January 2024 and was dispensed on medication cards in increments of thirty (30) tablets that is inconsistent with the number of documented administrations.

On 01/04/2024 at 11:20 AM, V23 (Licensed Practical Nurse) said R2 has a pain medication order daily as needed that was last documented as being administered on 09/14/2023 at 08:53 AM. When asked to see R2's medication card for ibuprofen, V23 was unable to produce a med card then indicated it was last ordered, dispensed and received on 01/02/2024 and is most likely in the first floor pharmacy box. V23 added that nursing is never allowed to administer a resident's medications to another resident.

On 01/08/2024 at 2:54 PM, observed with V36 (Licensed Practical Nurse) that R2's ibuprofen 800mg tab medication card with dispensed date of 01/02/2024, to have one tablet missing. Reviewed and confirmed with V36 per R2's electronic medication administration record that R2 was last documented as receiving this medication on 09/19/2023 at 08:53 AM. When asked when the current missing tablet was administered and whether it was received by R2, V36 said "I don't know because I wasn't here".

On 01/10/2024 at 1:43 PM, V3 (Assistant Director of Nursing) was asked why an as needed medication would be reordered frequently if the resident is rarely being administered this medication, why would the medication need to be reordered so often, V3 said sometimes the pharmacy sends a medication without the facility reordering it then said there would be no other

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reason for excessive reordering if the medication was not frequently being administered. When asked if there should then be a surplus of this medication available rather than none being available, V3 had no response. When R2's ibuprofen administration records and pharmacy reorder logs were reviewed by surveyor with V3, she was unsure as to why his medication would have been unavailable. V3 then added that her expectation is for nursing staff to document all medication administrations and if not documented, then it would be considered as not given and a medication error.

Ordering and Receiving Non-Controlled Medications From the Dispensing Pharmacy policy with effective date of 10/25/2014 reads in part: Policy: Medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. Procedures: Reordering of medications is done in accordance with the order and delivery schedule developed by the pharmacy providers. Reorder medication four (4) days in advance of need, as directed by the pharmacy order and delivery schedule, to assure an adequate supply is on hand.

R17 is a 65-year-old female who has resided at the facility since 2021, past medical history includes, but not limited to Nondisplaced transcondylar fracture of right humerus, subsequent encounter for fracture with routine healing, dementia in other diseases classified elsewhere unspecified severity without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, type 2 diabetes, Epilepsy unspecified, etc.

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On 1/4/2024 at 10:30AM, R17 was observed in her room, awake and alert with some confusion, stated that she gets aspirin for headache, she got one yesterday. R17 was asked if she gets any other medication for pain and she said, "I don't know".

Physician order summary showed the following active order for R17, Ibuprofen tablet 400 MG, give 1 tablet by mouth every 12 hours as needed for Pain, order date 10/17/2022.

Care plan dated 10/14/2022 R17 is at increased risk for alteration in pain/discomfort R/T DX of closed supracondylar FX of RT humerus s/p ORIF 10/14/22. Interventions include: Complete the Pain assessment upon Admission, Re-admission, Quarterly and PRN for new onset of pain, administer analgesic medication as ordered per plan of care, notify MD for any new resident complaints of pain and/or S/S of pain to obtain new order for medication regimen or break-through pain management, monitor for verbal and nonverbal expressions of pain, notify MD if interventions are not consistently effective.

On 1/3/2024 at 3:25PM, observed medication administration with V24 (LPN) for R17, V24 administered three medications to resident and stated that resident has an order for ibuprofen 400mg, she does not have it available, but she will go and pull from the emergency box. Resident stated that she has a headache and rated her pain as a 10 on a scale of 1 to 10. V24 did not come back with the Motrin until 4:20PM, surveyor did not observe V24 administer the medication.
Medication administration record (MAR) for the

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F 602	Continued From page 8 month of October 2023 shows that resident is on Ibuprofen 400mg to be given every 12 hours as needed, there was no signature indicating that the medication was administered to the resident the whole of October 2023. Review of pharmacy therapeutic report shows that the medication was dispensed in October 2023, has not been reordered until 1/3/2024. Resident is currently missing 3 tablets from the 30 tablets delivered to the facility on 1/3/2024, MAR for January 2024 does not have any documentation that the medication was given to the resident. On 1/8/2024 at 2:43PM, V3(DON) was asked what happened to the three missing tablets from the bingo card if there is no signature in the MAR indicating that they were given to R17 and she said, "I don't know". Medication administration policy and procedure revised 1/1/2020, presented by V1 (Administrator) states its purpose are to ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Under procedures, the policy states in item 8. The individual administering the medication shall initial the resident's medication administration record (MAR) on the appropriate line and date for that specific day before administering the medication.	F 602		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		1/23/24

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F 684	Continued From page 9 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to monitor and assess a resident's (R13) condition who was receiving blood thinner medication and had previous laceration; and failed to have an active care plan for a resident (R14) for diabetes care and act promptly to provide an intervention for a resident with low blood sugars. These failures involved two residents, R13 and R14. As a result, on 11/10/23 R13 was found lying in a moderate amount of blood in bed and sent to the hospital via 911 emergency. On 11/11/23 R14 was found lying on the floor unresponsive and sent out via 911 after paramedics administered a blood glucose check and which the result of was a hypoglycemic reading. Findings include: 1. R13 is 73 years old and was originally admitted to the facility 6/1/22 and has diagnoses of dementia, history of falling and other mental health disorders. According to the electronic health record, and facility fall reports, R13 had a fall in the facility on 10/25/23. From the fall incident, R13 sustained a laceration to the scalp and was sent to the hospital for evaluation. Physician Order Sheet dated 11/1/23 included order written by the Nurse Practitioner to remove staples. Treatment Administration Record for November 2023 was reviewed and noted that the staple removal order was signed off by a nurse with no further notes or assessment on 11/2/23 at	F 684	SS= D F684 Quality of Care CFR(s):483.25 Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice. " R13 remains safely in the facility and the laceration has healed without any complications. " R14 remains safely in the facility and has an active care plan in place for diabetes care. How the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. " Staff nurses (including identified V#□s) were in-service on monitoring and assessing a resident's condition who receives blood thinner medications that have previously had lacerations, ensuring diabetic care plans are in place, and acting promptly to provide interventions	

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12:40AM.

On 1/10/24 at 12:10PM V64 Nurse Practitioner explained that when staples are used in a scalp laceration, the purpose is just to hold the skin together to aid the process of healing. V64 went on to say, the scalp is very vascular and heals very quickly, so a laceration that was already treated and closed with staples would typically be healed in 3-4 days unless there was some type of complication such as an infection or reinjury to the site. Because this resident is actively taking a blood thinner medication, such as apixaban 5mg, they are at a higher risk of bleeding should an injury occur.

On 11/10/23 at 8:05AM, V51 LPN wrote a progress note stating "Nurse was made aware by therapist that resident needed to be evaluated. Upon entering room resident noted with blood to head and side of face. Resident is alert and oriented x1 which is baseline. Denies pain. [range of motion within normal limits]. [Vital signs assessment] [blood pressure] 102/78, [pulse] 68, [temperature] 97.9 [degrees Fahrenheit] [oxygen saturation] 98% [on room air]. Nurse had staff remain with resident and called 911 for resident to be transported. Resident remains alert and responsive. [Neurological] checks initiated. Noted [within normal limits]. Fire Department on scene and care of resident is transferred. Nurse called the Doctor and made aware ..."

On 1/3/24 at 11:15AM V68 Fire Department was interviewed and said that when the paramedics arrived to the facility, R13 was in bed and one side of the body was covered in blood. V68 noted that there was also a pool of blood on the floor as well as the bed. Some of the blood was bright

F 684

for residents with low blood sugar.

" A weekly audit is being completed by the Director of Nursing /or Designee on 5 residents per week to make certain residents who have lacerations and are on blood thinners are being monitored and assessed, making certain residents who have a diagnosis of diabetes have active care plans in place, and to promptly provide interventions for residents who have low blood sugar.

Quality Assurance plans to monitor facility performance to make sure that the corrections are achieved and are permanent:

" A QAPI tool was initiated by the Director of Nursing /or Designee on 5 residents per week to make certain residents who have lacerations and are on blood thinners conditions are being monitored and assessed, making certain residents who have a diagnosis of diabetes have active care plans in place, and to promptly provide interventions for residents who have low blood sugar.

" Results of the weekly audits will be analyzed through the monthly Quality Assurance and Performance Improvement Committee (QAPI). The Administrator and Medical Director will monitor the process. The Committee will determine if the audits continue after three months.

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red, and some was darker and dried. V64 said, since some of the blood appeared to already be dry, it looked as if R13 had been in that state for a while.

On 1/4/24 at 10:57AM V51 LPN said, I worked 7am-3pm shift on 11/10/23 but earlier that morning, I called someone to let the facility know that I would be coming late. By the time I arrived which was about 8:00AM, the night shift nurse was already gone, and I wasn't able to get report from anyone. Although there was another nurse on the floor, they did not give me a report. When I came in, I didn't do rounds right away, because I went to acclimate myself to the census and residents on the floor. I was printing out my census when the therapist yelled out and I came. When I saw R13 they were lying in a moderate amount of blood. There was so much blood on the body, bed and floor, that I was afraid to touch them too much because I couldn't determine where the blood was coming from. I did a quick assessment asking questions and while R13 was alert, they were confused, didn't know what happened and didn't even know anything was wrong. When the fire department came and took over, I charted the incident in the progress notes.

On 1/4/24 at 1:10PM V69 CNA (Certified Nursing Assistant) said, they were caring for R13 during the night shift and early morning of 11/10/23. V69 said they left early that morning at 6:30AM however before they left, they completed rounds and gave incontinence care to R14 around 5:00AM. V69 said that just as they were completing their care for R13, the nurse on duty came into the room to give medications. V69 said that R13 was left in good condition at that time and did not return to the room before leaving for

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the day.

On 1/4/24 at 1:26PM V30 RN (Registered Nurse) said, I gave medication to R13 around 5:00AM on 11/10/23 right after V69 finished giving care. I didn't see anything out of the ordinary, R13 was calm and not behaving unusually. After I gave the medications, I didn't return to the room because I finished passing medications, charting, and waited for the morning nurse to come. I waited 30 minutes over to give report to the nurse, but they were not there before I left, so I wrote out a report and endorsed it to the other nurse on the floor.

Medication Administration Record dated 11/10/23 indicates that V30 administered 6am medications including insulin which was signed out at 5:05AM.

On 1/9/24 at 3:10PM V2 Director of Nursing said, they were not made aware of V51 indicating that they would be late, and they were also unaware that the CNA assigned to R13 left before the shift ended at 7am. V2 said that they expect the nursing staff to make rounds on residents prior to leaving and at the beginning of the shift. V2 said that they did not investigate this incident because they didn't feel as if it was needed. V2 did agree however, that staff should have made rounds on R13 from 5am to 8am.

On 1/8/24 at 3:00PM V3 ADON (Assistant Director of Nursing) said nurses and CNAs are expected to make rounds at least every two hours to check on the resident status and needs. V3 also said that the nurses should have been documenting and assessing the laceration with staples and if there is no documentation of the assessments, there is no definitive way to determine if these assessments were being

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completed.

Care Plan for R13 was reviewed and noted that the plan for falls included updated interventions that were placed 11/13/23.

Hospital records dated 11/10/23 indicated that when R13 arrived to the hospital, there was a blood clot over a preexisting head laceration with staples in place. R13 was treated with intravenous fluids due to dehydration related to blood loss and two additional staples were applied to the wound for closure.

No further documentation of the head laceration was provided by the facility.

2. R14 is 66 years old and was admitted to the facility 9/25/23 with diagnoses that included Chronic Obstructive Pulmonary Disorder, Hypertension, Type II Diabetes Mellitus and Kidney Disease and Substance Abuse. Nursing progress note written on 11/11/23 at 1:25AM stated "Resident taken by 911 crew to hospital after a fall incident." No further documentation or assessment was noted in the Electronic Health Record regarding this concern.

V68 Fire Department was interviewed 1/3/24 at 11:05AM. V68 said, when his team of paramedics arrived on-scene, R14 was found unresponsive, breathing and lying on the floor. V68 said the nurse on duty refused to render care saying that they were not assigned to R14 and therefore not responsible for R14. V68 said that two facility staff were in the room on arrival, and they were not rendering care but told the paramedics that R14 may have been experiencing illicit drug overdose, as R14 had been previously treated for

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in the facility prior to this incident. V68 said they administered the antidote naloxone to R14; however, the condition was unchanged. After obtaining vitals and a blood glucose, R14's blood sugar measured 24mg/dl and paramedics administered 25 Grams of Dextrose intravenously. V68 said R14 was arousable after the dextrose, and they transported R14 to the hospital for evaluation. Fire Department Run-sheet was reviewed during this survey which corroborated this interview. V68 named the caller who was later identified by Surveyor to be V71 RN.

V71 RN was listed as the nurse on duty 11/10/23 for the 11PM-7AM shift and was unreachable during this Survey. On 1/8/24 at 3:00PM V3 Assistant Director of Nursing said, I was made aware of the situation when R14 was sent to the hospital. If I remember correctly, the Director of Nursing came in that night due to a call off. I am not sure why the nurses did not assess R14 prior to or after calling 911. I would have expected them to at minimum take vital signs such as blood pressure and blood glucose if the resident was taking insulin. The nurses have medications and equipment to treat residents for hypoglycemia in the facility if needed. If the resident is unconscious or lethargic, the nurses can administer glucagon medication to improve the blood sugar immediately. This medication is specific to the resident meaning it is ordered specifically for each resident and should be available to nursing staff, should be signed out on the Medication Administration Record and reordered after administration.

Medication Administration Record for November 2023 was reviewed and included an order:

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"Glucagon Emergency Injection Kit. Inject as per sliding scale: if 0-60 if less than 60 and unable to swallow give 1mg (milligram) subcutaneous and repeat in 45 minutes if [less] than 60 call [Medical Doctor], Intramuscularly as needed for if blood sugar [less than] 60 Start Date 11/09/2023."

On 1/9/24 at 3:00PM, V2 Director of Nursing said that they were notified around 12:30am that the unit R14 was placed on was short a nurse. V2 said that the shift started at 11:00pm and two nurses should have been on the unit at that time, however the nurse that did not come in was assigned to R14. V2 said that they were informed about R14's condition of being found unresponsive and by the time they arrived at the facility, around 2am, R14 had already transferred to the hospital. V2 said that no further action was taken, and no investigation was completed. When the Medication Administration Record was reviewed, it was noted that evening medications were not signed out for 4PM and 8PM. V2 said, that it was difficult to determine what nurse was assigned to R14 and that since they did not complete an investigation regarding R14's state prior to being found unresponsive and since the medications were not signed out, including insulin, V2 could not determine whether R14 received medications. V2 said that the expectation is for all medications to be signed out as they are given, and all medications should be given as ordered.

On 1/10/24 at 12:04PM V64 Nurse Practitioner said that they assessed R14 on 1/10/24 and was aware that R14 was taking medications for diabetes. V64 explained that a "normal" blood sugar ranges from 70-90 and that it was very important to correct a low blood sugar quickly

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F 684	Continued From page 16 before it declines further. V64 said when blood sugar levels are critically low, the patient may have symptoms including becoming incoherent, unconscious, or falling into a diabetic coma. V64 said, in a controlled environment such as in the nursing facility, it is uncommon for this to happen, because the nursing staff is expected to monitor the residents for signs and symptoms before this type of severity takes place. At the time of this survey, R14 did not have an active care plan for the management of diabetes.	F 684		
F 689 SS=G	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 interview and record review, the facility failed to provide adequate supervision, assistive devices and proper transfer technique to prevent a fall of 1 (R1) of 3 residents reviewed for accident/hazards in the sample. This failure resulted in R1 being emergently transferred to the hospital after a mechanical fall during transfer from bed to chair causing excruciating pain and femoral fracture. Findings include: R1 is a 71 year old resident with diagnosis of	F 689	SS= G F689 Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice. " R1 no longer resides in the facility. How the facility will identify other residents	1/23/24

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spinal stenosis, lack of coordination, heart failure, end stage renal disease, absence of left leg above knee amputation, absence of right leg below knee amputation, and femur fracture.

MDS (Minimum Data Set) dated 11/1/2023 assessed resident's ability to perform chair/bed-to-chair transfer and states, "The ability to transfer to and from a bed to a chair (or wheelchair). Not attempted due to medical condition or safety concern."

Records showed:

On 10/18/23 at 1:14 PM V27 (LPN/Licensed Practical Nurse) wrote, "Patient being sent to hospital for x-rays to rule out possible injury for right hip/leg that occurred during transfer from bed to specialty chair." Calls to interview V27 went unanswered and V27 is no longer an employee of the facility.

V2 (Director of Nursing) interview with V11 (CNA/Certified Nurse's Aide) "Spoke to (V11) and she stated she transferred (R1) with a bear hug. The resident was complaining of pain prior to transfer. She stated R1 did not hit her leg on the chair nor bed."

Efforts to contact V11 (CNA) on 1/3/24 and 1/4/24 were left unanswered and V11 is no longer an employee of the facility.

Care plan dated 10/13/23 states, "Resident is at risk for falls related to falls. Goal: Will have no serious fall related injury through next review. Interventions: Be sure call light is within reach and encourage the resident to use it for assistance as needed. Staff to respond promptly

F 689

having the potential to be affected by the same deficient practice.
" All residents who reside in the facility have the potential to be affected by this alleged deficient practice.

Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.

" The Facility nursing department (including identified V#□s) were in-service on providing adequate supervision, assistive devices, and proper transfer techniques to prevent falls.

" A weekly audit is being completed by the Restorative Nurse /or Designee on 5 residents per week to make certain that residents are provided adequate supervision, assistive devices, and proper transfers to prevent falls.

Quality Assurance plans to monitor facility performance to make sure that the corrections are achieved and are permanent:
" A QAPI tool was initiated by the Restorative Nurse /or Designee on 5 residents per week to make certain that residents are provided adequate supervision, assistive devices, and proper transfers to prevent falls.
" Results of the weekly audits will be analyzed through the monthly Quality Assurance and Performance Improvement Committee (QAPI). The Administrator and Medical Director will

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to all requests for assistance. Anticipate and meet individual needs of the resident. Complete the Fall Risk Review per the facility protocol."

A facility fall protocol policy was requested but was never provided during the course of the survey.

R1's fall risk assessment dated 10/12/23 assessed by V31 (LPN) showed R1 to be a moderate risk for falls.

On 1/8/24 at 11:30 AM, V3 (Assistant Director of Nurses) stated, "I remember this resident, but she was not here long. She was being transferred by this CNA (V11) and this CNA wasn't here long either. She was being transferred from bed to chair to get to dialysis and I think she may have fallen but I'm not sure how she got the fracture." Surveyor asked how this resident should have been assisted from bed to chair, V3 stated that the resident required a mechanical lift, "so the way this aide transferred her was inappropriate to transfer resident in a bear hug method."

On 10/18/23 at 12:20, V33 (Nurse Practitioner) noted, "Nurse approached writer stating patient was being transferred from bed to wheelchair to go to dialysis when patient stated she heard a "pop" in her right hip and patient screaming in excruciating pain. Patient seen reclined in geriatric chair and crying in pain "I heard a pop in my hip, I know it ' s broken". Upon palpation, right hip deformity noted, unclear if patient position in wheelchair/ or due to injury. Initially stat x-ray ordered of right hip, but radiology could not give a timeframe of when x-ray would be completed. Order given to send patient to hospital for further assessment."

monitor the process. The Committee will determine if the audits continue after three months.

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F 689		F 689		

Continued From page 19

On 10/19/23 at 8:20 PM, V34 (RN) noted, "Writer called hospital; resident to be admitted with diagnosis of femoral fracture, hepatic lesion, and pleural effusion."

Hospital records dated 10/18/23 authored by V72 (Emergency Department Doctor) reads, "This is a 71 year old female patient on Eliquis (blood thinner), congestive heart failure with preserved ejection fraction, COPD on home oxygen 3 liters, hyperlipidemia, prior stroke, peripheral artery disease status post right BKA (Below the knee amputation) and left AKA (Above the Knee Amputation) presents to the emergency department today from dialysis center for severe pain and deformity of her right thigh. Patient in excruciating pain so it is somewhat difficult to get the full story of what happened. Apparently, she was being transferred from 1 bed to the dialysis when her right leg was injured. There was immediate deformity of the right femur and pain over the site with tenting of the skin. Patient denies change in temperature or color or paresthesia of the limb distal to the deformity. Patient ultimately was reduced at bedside with orthopedic surgery. Patient received pain dosages of ketamine and fentanyl and tolerated the procedure decently well. Vascular surgery consulted and will follow inpatient but no indication for heparinization at this time. Social work consult placed to assess for safety at nursing home given severe injury with unclear mechanism. Discussed with hospitalist for admission."

Surveyor asked facility for policies related to the safe transfer of residents from bed to chair and was provided an ADL (activities of daily living)

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F 689	Continued From page 20 policy that reads, "Activities of daily living (ADLS) reads in part, "Transfers (standing pivot). Apply gait belt per plan of care, position resident to assist with further transfer. Place hands correctly (Do not hold under the arms) Provide cues to resident to let them know what you are doing. Assist resident to stand, using appropriate body mechanics. Pivot resident to the chair or bed, then lower slowly asking them to reach back for the chair."	F 689		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must	F 725		1/23/24

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F 725	Continued From page 21 designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide sufficient nursing coverage on specific days and shifts, causing call lights not to be answered and not ensuring adequate resident care and assistance for three of three residents (R4, R8 and R13) reviewed for staffing. Findings Include: Per residents' census report dated 01/02/24, there are 186 residents currently residing in the facility. On 01/02/24 at 2:23 PM, R4 mentioned during an interview that call lights were not answered by staff in a timely manner. R8 and R13 verbalized concerns regarding staffing in the facility. R4, R8 and R13 stated call light responses, provision of care and necessary support from staff were issues due to lack of staff. V38 (Staffing Coordinator) was interviewed on 01/08/24 at 9:27 AM regarding staffing. V38 stated, "The facility has three floors, first floor is both short term and long term; Second floor is long term. Residents on the second floor all need total care, are dependent on staff for ADLs (activities of daily living), and need constant supervision and monitoring. A lot of residents on the second floor are verbal, some are ambulatory. Third floor is long-term, verbal and ambulatory." V38 was asked regarding number of staff needed on each shift on all three floors. V38 replied, "Each shift: first floor needs two CNAs and two nurses; second floor needs five CNAs and two	F 725	SS= D F725 Sufficient Nursing Staff CFR(s)(a)(1)(2) Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice. " R4, R8, and R13 remain safely in the facility with their call lights being answered timely and continue to receive adequate care and assistance. How the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents who reside in the facility have the potential to be affected by this alleged deficient practice. Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. " The Facility nursing department (including identified V#□s) were in-service to ensure the facility has sufficient nursing coverage on specific days and shifts and to make certain call lights are answered, and residents receive adequate care and assistance. " A weekly audit is being conducted by the DON and/or designee on 5 residents	

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nurses; and third floor needs two CNAs and two nurses. CNAs shift schedules are 7 AM -3 PM; 3 PM - 11 PM and 11 PM - 7 AM. For nurses: it is 6:30 AM - 3 PM, 2:30 PM - 11 PM and 10:30 PM - 7 AM. In cases of call ins, I call staff if someone can pick up. If none, nurse managers, restorative nurses or CNAs pick up. In cases of tardiness, we log and do some disciplinary actions, two tardiness result in disciplinary actions." Each shift requires 6 nurses and at least 9 CNAs in the facility.

On 01/08/24 at 12:05 PM, it was observed that V37 (Certified Nursing Aide) was the only CNA working on the third floor in the facility. V36 (Licensed Practical Nurse, LPN) was asked regarding staffing concern. V36 stated, "We only have one CNA today, V37. We usually have two CNAs. We have 59 residents on the floor."

According to the Daily Staff schedule dated 01/08/24, V37 and V54 are assigned to work on the third floor. V54 was absent.

Review of staff weekend time sheets dated November to December 2023 recorded the following numbers of staff worked per shift for the whole facility:

11/5: morning shift had 5 nurses. V31 (LPN) came in at 7:18 AM. V31 was assigned on the second floor. Afternoon shift had 6 CNAs only and night shift had 3 nurses and only one CNA for the three floors.

11/11: 8 CNAs worked during morning shift. Afternoon shift had 10 CNAs, however, V55 (CNA) left at 10:02 PM and V13 (CNA) at 8:02 PM. Night shift had 3 nurses, V58 (LPN) came in

F 725

per week to ensure there is sufficient nursing coverage and to make certain the call lights are answered, and the residents are provided adequate care and assistance.

Quality Assurance plans to monitor facility performance to make sure that the corrections are achieved and are permanent:

" A QAPI tool was initiated by the DON and/or designee to ensure there is sufficient nursing coverage and to make certain the call lights are answered, and the residents are provided adequate care and assistance.

" Results of the weekly audits will be analyzed through the monthly Quality Assurance and Performance Improvement Committee (QAPI). The Administrator and Medical Director will monitor the process. The Committee will determine if the audits continue after three months.

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F 725	Continued From page 23 at 11:20 PM. 11/12: Afternoon shift had 9 CNAs, but CNAs V39 left at 9:19 PM and V19 at 9:51 PM. 11/18: - Morning shift had 6 CNAs; afternoon shift had 7 CNAs; V46 (CNA) came in at 4:45 PM. 11/19: 8 CNAs worked during morning shift; 7 CNAs worked in the afternoon shift with CNA V43 leaving at 6:37 PM. 5 nurses also worked in the afternoon shift with V9 (LPN) leaving at 8 PM. Night shift had 3 nurses and 3 CNAs. 11/25: Afternoon shift had 9 CNAs, however V46 left at 8:12 PM, V54 (CNA) left at 10:04 PM and V55 worked until 10:05 PM. Night shift had 3 nurses, V58 came in at 11:15 PM. 11/26 - Morning shift had 8 CNAs. 6 CNAs worked in the afternoon shift, V43 left at 9:46 PM and V60 (CNA) worked until 7:52 PM. Night shift had 3 nurses; 6 CNAs. V58 came in at 11:11 PM. 12/2: 8 CNAs worked in the morning shift; 7 CNAs worked in the afternoon shift. Night shift had 1 CNA. 12/3: 6 nurses and 6 CNAs worked during morning shift. However, V31 came in at 7:44 AM, V36 (LPN) also came in at 7:40 AM. V56 (Registered Nurse, RN) left at 1:30 PM. There were 5 nurses who worked during afternoon shift with 7 CNAs. V21 (CNA) left at 8:35 PM. Night shift had 5 CNAs. 12/9: 8 CNAs worked in the afternoon shift, V55 worked until 8:53 PM. Night shift had 3 nurses, V58 came in at 11:31 PM.	F 725		

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F 725	Continued From page 24 12/10: Afternoon shift had 5 nurses and 8 CNAs. V39 left at 10:06 PM and V43 left at 9:30 PM. Night shift had 4 nurses, V58 came in at 11:13 PM. 12/16: Afternoon shift had 7 CNAs, V50 (CNA) worked until 8:52 PM, V39 left at 10:04 PM and V55 left at 9:23 PM. Night shift had 3 CNAs. 12/17: 6 CNAs worked in the morning shift, V62 (CNA) left at 12:55 PM. Night shift had 3 nurses and 4 CNAs. 12/23 - Morning shift had 5 nurses and 8 CNAs. V24 (LPN) came in at 8:02 AM, V36 came in at 10:01 AM. Afternoon shift had 5 CNAs, V13 left at 8:31 PM, V48 (CNA) left at 9:59 PM and V39 worked until 10:30 PM. Night shift had 4 nurses and 5 CNAs. 12/24: Morning shift had 5 nurses. Afternoon shift had 5 nurses. Night shift had 4 nurses, V58 came in at 11:10 PM. 12/30: 5 nurses and 5 CNAs worked in the morning shift. Afternoon shift had 3 CNAs and night shift had 2 CNAs. 12/31 - Afternoon shift had 6 nurses and 9 CNAs. V41 (LPN) worked until 8:03 PM, V31 left at 8:29 PM, V30 (LPN) left at 10:18 PM, V52 (RN) worked until 8:49 PM, V25 (RN) left at 9:11 PM. V48 worked until 9:04 PM. V39 left at 9:19 PM, V19 left at 9:55 PM, V21 left at 8:42 PM and V53 (CNA) worked until 7:32 PM. Night shift had 2 nurses and 1 CNA. The one CNA, V47, worked until 4:51 AM.	F 725		

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F 725	Continued From page 25	F 725		

Daily nurses' schedule for weekends of November 2023, showed that only one nurse is scheduled on the first floor and one nurse on the third floor during night shift. On 12/02/23 and 12/03/23, one nurse worked on the first floor. On 12/09/23 to 12/31/23, only one nurse worked on the first floor and one nurse on the third floor.

On 01/08/24 at 10:10 AM, V1 (Administrator) was asked regarding staffing issues in the facility. V1 stated, "I know that we need to hire nurses and CNAs because there is a turnover of staff, we need to hire and replace staff who have left. Human Resources gets resumes of potential nurses and CNAs, applicants and hiring. Human Resources is responsible for call ins, tardiness. Our DON (V2, Director of Nursing) is still on medical leave."

On 01/08/24 at 10:28 AM, V35 (Human Resources Manager) was interviewed regarding staff absences and tardiness. V35 replied, "No, I am not responsible for staff call - ins and tardiness. I am responsible for hiring. I know that they do a lot of call - ins, no call, no show and tardiness. I encouraged department managers to go with the handbook and union handbook regarding disciplinary actions."

V3 (Assistant Director of Nursing) was interviewed on 01/08/24 at 11:20 AM regarding staffing. V3 verbalized, "I am responsible for staffing in terms of making sure we have enough staff on the floor. We have staff shortage for both CNAs and nurses. Most of the staff they stay over, they pick up the hours. Some staff stay over if some wants to leave early, they let us know early and we give them permission. Sometimes, we get somebody, ask other staff to come. On

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F 725	Continued From page 26 weekends, managers come. We know the schedule, we have shortage. The managers know that they have to come to work on the shift." On 01/09/24 at 9:48 AM, V2 stated during interview, "I am not aware of any issues with staffing. We do have normal call offs, but other than that, we don't have any issues. In cases of call ins, I call staff to come in and make sure sufficient number of staff is working on the floor. We try to find somebody to come, we don't use agency staff. For some staff who will be late or will be absent, they inform us, managers or scheduler." Facility's policy titled, "Staffing", undated, stated in part but not limited to the following: Purpose: 1. To have appropriate amount of nursing staff on a daily basis. 2. To render quality nursing care.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility	F 755		1/23/24

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F 755	Continued From page 27 must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide medications and/or biologicals, as ordered by the prescriber to meet the needs of each resident and failed to provide pharmaceutical services to meet each resident's needs which includes acquiring, receiving, dispensing, accurately administering, or disposing of medications. This failure affected one resident (R17) of four residents reviewed for medication administration, causing the resident to endure pain related to not having pain medication available when needed. Findings include: R17 is a 65-year-old female who have resided at the facility since 2021, past medical history includes, but not limited to Nondisplaced transcondylar fracture of right humerus, subsequent encounter for fracture with routine healing, dementia in other diseases classified elsewhere unspecified severity without behavioral	F 755	SS= D F755 Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s)483.45(a)(b)(1)-(3) Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice. R17 remains safely in the facility and continues to receive medications as ordered by the prescriber. How the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents who reside in the facility have the potential to be affected by this alleged deficient practice.	

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F 755	Continued From page 28 disturbance, psychotic disturbance, mood disturbance and anxiety, type 2 diabetes, Epilepsy unspecified, etc. On 1/3/2024 at 3:25PM, observed medication administration with V24 (LPN) for R17, V24 administered three medications to resident and stated that resident has an order for Motrin 400mg, she does not have it available, but she will go and pull from the emergency box. Resident stated that she has a headache and rated her pain as a 10 on a scale of 1 to 10. V24 did not come back with the Motrin until 4:20PM, surveyor did not observe V24 administer the medication. Surveyor asked V24 why the resident did not have the medication and she said that since it is ordered as needed, sometimes pharmacy will send it and sometimes they do not, V24 did not mention using house stock for resident when they don't have their own. V24 was asked when last resident's Motrin was reordered, and she said in October. At 3:40PM, observed medication administration with V25 (RN), surveyor asked her if they normally have Motrin house stock and she said, "sometimes we do, sometimes we don't". Physician order summary showed the following active order for R17, Ibuprofen tablet 400 MG, give 1 tablet by mouth every 12 hours as needed for Pain, order date 10/17/2022. Care plan dated 10/14/2022 states: resident is at increased risk for alteration in pain/discomfort R/T DX of closed supracondylar FX of RT humerus s/p ORIF 10/14/22. Interventions include: Complete the Pain assessment upon Admission,	F 755	Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur. " Facility nurses (including identified V#□s) were educated on providing medications and/or biologicals, as ordered by the prescriber to meet the needs of each resident and to provide pharmaceutical services to meet each resident□s need with an emphasis on acquiring, receiving, dispensing, and accurately administering or disposing of medications. " A weekly audit is being conducted by the DON and/or designee on 5 residents per week to make certain residents are provided medications and/or biologicals, as ordered by the prescriber to meet the needs of each resident and to provide pharmaceutical services to meet each resident□s needs ensuring the facility acquire, receive dispense, and accurately administering or disposing of medications. Quality Assurance plans to monitor facility performance to make sure that the corrections are achieved and are permanent: " A QAPI tool was initiated by the DON and/or designee to make certain residents are provided medications and/or biologicals, as ordered by the prescriber to meet the needs of each resident and to provide pharmaceutical services to meet each resident□s needs ensuring the facility acquire, receive dispense, and accurately administering or disposing of	

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F 755	Continued From page 29 Re-admission, Quarterly and PRN for new onset of pain, administer analgesic medication as ordered per plan of care, notify MD for any new resident complaints of pain and/or S/S of pain to obtain new order for medication regimen or break-through pain management, monitor for verbal and nonverbal expressions of pain, notify MD if interventions are not consistently effective. On 1/4/2024 at 10:30AM, R17 was observed in her room, awake and alert with some confusion, stated that she gets aspirin for headache, she got one yesterday. R17 was asked if she gets any other medication for pain and she said, "I don't know". R17 added that she gets her medications all the time, they sometimes run out of her phenobarbital, but it is not a big deal. ON 1/4/2023 at 10:25AM, V3 (ADON) said that medications should be ordered when they run out including as need medications. Regarding Ibuprofen, pharmacy sends it for some residents depending on their insurance and for other residents they use the house stock. V3 said that the facility does not have Ibuprofen the Emergency Medication Supply. V3 stated that they were out of the house stock Motrin, they placed an order yesterday, and the administrator went to the store yesterday to buy some after the nurse reported that she does not have any for a resident (R17). On 1/4/2024 at 10:35AM, V9 (LPN) said that she has Ibuprofen in her medication cart on the first floor, it is a brand-new bottle, she got it and it is not opened yet. At 10:40AM, another nurse on the second floor stated that she has a new bottle of Motrin in her cart, it is brand new and is not opened yet.	F 755	medications. " Results of the weekly audits will be analyzed through the monthly Quality Assurance and Performance Improvement Committee (QAPI). The Administrator and Medical Director will monitor the process. The Committee will determine if the audits continue after three months.	

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F 755 Continued From page 30 F 755

On 1/4/2024 at 10:45AM, V26 (LPN) said that pharmacy sends Ibuprofen for residents, they usually have a small bottle of house stock but now she has a brand-new bottle that is not open yet.

Medication administration record (MAR) for the month of October 2023 shows that resident R17 is on Ibuprofen 400mg to be given every 12 hours as needed, there was no signature indicating that the medication was administered to the resident the whole of October 2023. Review of pharmacy therapeutic report shows that the medication was dispensed in October 2023, has not been reordered until 1/3/2024. Resident is currently missing 3 tablets from the 30 tablets delivered to the facility on 1/3/2024, MAR for January 2024 does not have any documentation that the medication was given to the resident.

Medication administration policy and procedure revised 1/1/2020, presented by V1 (Administrator) states its purpose is to ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. Under procedures, the policy states in item 3. Medication shall be administered in physician's written/verbal orders upon verification of the right medications, dose, route time, and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standard. 8. The individual administering the medication shall initial the resident's medication administration record (MAR) on the appropriate line and date for that specific day before administering the medication.

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F 880	Continued From page 31	F 880		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		1/23/24

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F 880	Continued From page 32 (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 properly prevent and contain the spread of Covid-19 and other infectious diseases by failing to ensure a posting at the entrance to the facility of active Covid-19 infection; failing to implement source control measures regarding the use of face masks when Covid-19 is present in the facility; failing to ensure alcohol based hand rub was available in the PPE	F 880	SS = F F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) Corrective actions that will be accomplished for those residents found to have been affected by the deficient practice.	

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(personal protection equipment) carts for transmission based precaution isolation rooms; failing to ensure dedicated or disposable non critical resident care equipment was available for transmission based precaution isolation rooms; and failing to ensure all residents, their representatives and families were notified following the occurrence of either a single confirmed infection of Covid-19 or three or more residents or staff with new onset of symptoms. This failure has the potential to affect all 187 residents in the facility.

Findings include:

On 1/2/24 at 10:25 AM, upon entrance to the facility there are no signs posted identifying active Covid-19 infection. The receptionist desk has a sign posted on the glass indicating masks are optional. V1 Administrator and V4 Nurse Consultant said, "We have Covid residents." V1 Administrator said, "We have four residents that are isolated on second floor." Observed multiple residents and staff not wearing face masks or an N95 masks upon entrance to the first floor.

On 1/3/24 at 10:55 AM, R20, R21, and R22 are currently on droplet precaution isolation. The PPE (Personal Protective Equipment) cart at the room entrance does not have alcohol based hand sanitizer to use prior to putting on or removing PPE or dedicated/disposable medical equipment (blood pressure cuff, stethoscope, thermometer) inside the cart for the residents isolated.

At 10:57 AM, V13 CNA (Certified Nurse Assistant) was observed preparing to enter R20, R21, and R22's room. She did not perform hand hygiene prior to donning the isolation gown or gloves.

F 880

" All 187 residents remain safely in the facility and have not been affected by the alleged deficient practices.
" A posting has been placed visibly at the front entrance door indicating the facility has active COVID-19.
" The facility staff and residents have been educated on source control and the proper use of face masks.
" Alcohol-based hand rub is readily available in the PPE (personal protective equipment) cart for use.
" Disposable noncritical resident care equipment is readily available for use.
" All residents and resident representatives and families have been informed of the COVID-19 outbreak

How the facility will identify other residents having the potential to be affected by the same deficient practice.
" All residents who reside in the facility have the potential to be affected by this alleged deficient practice.

Measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur.

" Facility staff (including identified V#□s) were in-serviced on preventing and containing the spread of COVID-19 and other infectious diseases with an emphasis on ensuring postings of active COVID 19 infection are at the entrance of

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F 880	Continued From page 34 V13 CNA was inquired of isolation precautions. V13 CNA said, "There's no hand sanitizer on the cart. They're on the wall but they're a distance away." At 11:15 AM, R19 is on droplet isolation precautions. The PPE cart at the room entrance does not have alcohol based hand sanitizer to use prior to putting on or removing PPE. There are no N95 masks in the cart. Multiple residents and staff are not wearing surgical masks or N95 masks on the 1st, 2nd, and 3rd floors. R18 is on enhanced contact isolation precautions. The PPE (Personal Protective Equipment) cart at the room entrance does not have alcohol based hand sanitizer to use prior to putting on and removing the equipment. There are no gloves in the cart. At 11:20 AM, R24, R25, and R26 are not wearing face masks while sitting in the hallway at the nurse's station. There are two nurses seated at the nurse's station and neither staff member attempted to encourage the residents to wear a face mask. On 1/4/24 at 12:34 PM, V28 Infection Preventionist was interviewed regarding infection control and Covid-19 active infections and posting. V28 said, "R19 was positive with Covid from the hospital Thursday December 28 when he came back from the hospital. I had the entire facility tested on December 29th, staff, and residents. On Monday December 25th R20, R21, and R22 tested positive. Tuesday January 2nd was the next testing day and I got results Wednesday at 1PM with 8 more residents. We	F 880	the facility, implementing source control measures with an emphasis on wearing a face mask when Covid-19 is present in the facility, ensuring alcohol-based hand rub is available in the PPE (personal protective equipment) carts for transmission base rooms, ensuring dedicated or disposable non-critical resident care equipment is available for transmission based precaution isolation rooms, and making certain residents and their representatives and families are notified following the occurrence of a single confirmed Covid-19 infection. " A weekly audit is being conducted by the DON and/or designee on 5 residents per week to prevent the spread of COVID-19 and other infectious diseases with emphasis on ensuring postings of active COVID 19 infection are at the entrance of the facility, implementing source control measures with an emphasis on wearing a face mask when Covid-19 is present in the facility, ensuring alcohol-based hand rub is available in the PPE (personal protective equipment) carts for transmission base rooms, ensuring dedicated or disposable non-critical resident care equipment is available for transmission based precaution isolation rooms, and making certain residents and their representatives and families are notified following the occurrence of a single confirmed Covid-19 infection. Quality Assurance plans to monitor facility performance to make sure that the	

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F 880	Continued From page 35 don't have a number for an outbreak. The optional mask sign was posted. We have 12 positive residents now. The receptionist should have let visitors know we had residents with Covid. I told the staff myself. The receptionist is not infection control staff. Our receptionist is the only way we inform visitors of Covid. I believe there is an email that goes out to the residents and families. The infection preventionist is responsible for that, that would be me. We are going to initiate that now. R19's family was informed and the staff on his floor. I didn't send any communication to any other family member." There is no documentation in the resident's electronic medical records regarding the notification of the active Covid-19 infection in the building on December 28th. Multiple residents and staff are not wearing surgical masks or an N95 mask on 3rd floor. At 1:30 PM, V57 CNA (Certified Nurse Assistant) was observed in the 3rd floor hallway not wearing a face mask. V57 was inquired of not wearing a mask. V57 said, "I forgot to put one back on." V23 LPN (Licensed Practical Nurse) was observed sitting at the 3rd floor nurse's station not wearing a face mask. V23 was inquired of not wearing a mask. V23 said, "I just came back from my break, I haven't put it back on yet." On 1/8/24 at 9:40 AM, upon entrance to the facility, the receptionist is sitting at the front desk not wearing a face mask. At 10:28 AM, V28 was inquired the facility's current Covid-19 status. V28 said, "Currently we have 26 residents and 1 staff positive for Covid. On Friday we received 14 new residents and 1 staff positive on Friday January 5th. All the	F 880	corrections are achieved and are permanent: " A QAPI tool was initiated by the DON and/or designee to prevent the spread of COVID-19 and other infectious diseases with an emphasis on ensuring postings of active COVID 19 infection are at the entrance of the facility, implementing source control measures with an emphasis on wearing a face mask when Covid-19 is present in the facility, ensuring alcohol-based hand rub is available in the PPE (personal protective equipment) carts for transmission base rooms, ensuring dedicated or disposable non-critical resident care equipment is available for transmission based precaution isolation rooms, and making certain residents and their representatives and families are notified following the occurrence of a single confirmed Covid-19 infection. " Results of the weekly audits will be analyzed through the monthly Quality Assurance and Performance Improvement Committee (QAPI). The Administrator and Medical Director will monitor the process. The Committee will determine if the audits continue after three months.	

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F 880	Continued From page 36 residents are on the 2nd floor. I don't have a Covid unit. I'm going to talk to the administrator about that. The regional corporate nurse said the information she gave me was incorrect. The non positive resident's family were supposed to be called." At 10:34 AM, R23 is getting off the elevator and is not wearing a face mask. R23 was inquired of knowing if she was informed of the need to wear a face mask. R23 said, "Everybody is getting Covid. I have one from last time, but I don't know where it is." At 10:37 AM, V28 Infection Preventionist was inquired of transmission based precautions and infection control related to the current Covid-19 outbreak. On the 2nd floor there are three resident rooms designated as being on droplet precautions with their room doors open to the hallway. V28 confirmed the rooms are being isolated for Covid-19. V28 said, "Yes, they're on droplet precautions for Covid; R22, R21, and R20. The room doors should be closed to prevent the droplets from contaminating the hallway." During observations of the 2nd floor, there are multiple PPE (Personal Protective Equipment) carts for the transmission based droplet precautions without hand sanitizer and dedicated/disposable medical equipment (blood pressure cuff, stethoscope, thermometer) inside the carts for the residents isolated. At 10:39 AM, V28 was inquired of the components needed for transmission based precaution and dedicated/disposable medical equipment (blood pressure cuff, stethoscope,	F 880		

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thermometer) inside the PPE cart for the residents isolated. V28 said, "You should sanitize your hands before putting on PPE. They're missing hand sanitizer. I'm missing the stethoscope, blood pressure cuff and thermometers. I'm ordering some, but I didn't order thermometers."

At 10:54 AM, V28 Infection Preventionist was inquired of V32 Receptionist not wearing a face mask. V28 said, " V32 is at the desk by herself."

At 1:00 PM, V1 Administrator was inquired of informing residents and visitors of the facility's Covid-19 outbreak status. V1 said, "V4 Nurse Consultant worked remotely yesterday. She sent out the communication for Covid to the residents and families."

Review of the 1/7/2024 illness outbreak communications in the electronic medical records indicates the facility has a resident positive with Covid-19. There is no prior documentation of the facility informing the residents, their representatives, and families of the active Covid-19 infection as of December 28, 2023.

At 1:08 PM, multiple residents on the 1st, 2nd, and 3rd floors are not wearing face masks. Staff in the hall and nursing stations are not encouraging the residents to wear face masks related to the Covid outbreak.

At 2:00 PM, V28 was inquired of Covid positive staff. V28 said, "I have one staff positive; I got the results last Friday. I'll check if anyone else is positive." V28 was inquired for a copy of the facility's full Covid-19 policy that addresses staff and visitors.

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At 2:52 PM, V28 was inquired of current staff positive with Covid-19. V28 said, "I have two staff who are positive for Covid-19 now."

On 1/9/24 at 12:44 PM, V28 was inquired of informing staff of the active Covid-19 infections in the facility. V28 said, "On December 28th, I started in-services on wearing face masks in the facility because I had 3 positive Covid residents, it was for source control. I did an in-service on Covid testing twice a week for staff and residents. I also did one on hand washing and wearing proper PPE (personal protection equipment) while in isolation rooms." V28 was inquired why there are so many staff not wearing face masks while the facility is having active Covid-19 infections and the facility policy for staff regarding Covid. V28 said, "I'm not able to answer that, they knew to wear the masks because I had positive residents. I asked V4 Nurse Consultant and the Covid policy for residents is the only one we have. I can ask for the facility Covid policy."

On 1/10/24 at 10:35 AM, three staff are at the first floor nursing station wearing face masks under their chin. V3 ADON is also at the nursing station and is not encouraging the staff to properly wear their face masks.

At 11:56 AM, V38 Scheduler was not wearing a face mask while in the elevator with a fellow surveyor. Three residents entered the elevator. One resident did not have a face mask on. Two residents were wearing their face masks under their chins. V38 did not encourage the residents to properly wear their face masks.

At 1/10/24 at 1:50 PM, V3 ADON (Assistant

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Director of Nursing) was inquired of staff inappropriately wearing face masks with active Covid-19 infections in the facility. V3 said, "Staff are aware of the Covid positive residents. If I see it, I ask them to wear the mask properly. It's to prevent the spread of the infection. I didn't pay attention to the staff at the desk."

At 3:32 PM, V28 was inquired of any new active Covid-19 infections. V28 said, "I have six new residents that tested positive today. I had 4 residents that came off isolation. One came off January 8th and three came off January 9th. I have 27 residents all together with Covid. I checked with V4 Nurse Consultant, and we don't have any other policy for Covid."

Review of the updated Covid-19 line list provided by V28 confirms six additional residents diagnosed with Covid on 1/9/2024.

V28 Infection Preventionist did not provide the copy of the facility's full Covid-19 policy that addresses staff and visitors for review during the survey.

The 11/2022 Infection Control Policy states in part:
Purpose: to establish methods and criteria, necessary within the facility and its operation, to prevent, and control infections and communicable diseases.Responsibility: All employees and Quality Assurance Committee. Policy: It is the policy of this facility to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment, and to prevent or eliminate, when possible, the development and transmission of disease and infection. Standards: 14. All facility personnel

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F 880	Continued From page 40 shall adhere to the Infection Control Program in the performance of their daily assignments. Employees disregarding the facility's policies and procedures shall be retrained as necessary, disciplined, and may be discharged for repeated non-compliance. 16. The facility shall assure that necessary training, equipment, and supplies are maintained to carry out an effective infection prevention program. 18. Hand washing is essential. Alcohol based hand rubs/gels is the gold standard of prevention. The revised 12/2023 Transmission Based Precautions Policy states in part: Purpose To establish transmission based precautions for residents who are suspected or confirmed to have communicable diseases/infections that can be transmitted to others. Procedure: Droplet precautions. 3. Prior to entering the isolation room, the following steps are required: a. perform hand hygiene and apply gloves and mask prior to entering room. The 11/8/2022 Care for Residents with Suspected or Confirmed SARS-CoV2 Infection or Close Contact of Someone with Confirmed COVID-19 Infection policy states in part: Purpose: Establish a guideline to help prevent the transmission of SARS-CoV2 infection. Procedure: Residents with Confirmed Covid-19 1. Resident placement: single room with door closed if safe to do so. 3. Isolate using transmission based precautions. 5. Monitor the resident every four hours for clinical worsening. Include an assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and to quickly manage serious infections. 8. In general, residents should continue to wear source control until symptoms resolve or for those who never	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGO RIDGE SNF	10602 SOUTHWEST HIGHWAY CHICAGO RIDGE, IL 60415

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 41	F 880		

developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for residents.
9. Use dedicated medical equipment. Resident Placement (Covid Unit): The facility could consider designating entire units within the facility, with dedicated HCP Health Care Providers, to care for residents with SARSCoV2 infection when the number of residents with SARSCoV2 infection is high.

The Department of Health and Human Services
Centers for Medicare & Medicaid Services
Ref: QSO-23-13-ALL May 01, 2023
Guidance for the expiration of the Covid-19 Public Health Emergency
Memorandum Summary
Long Term Care and Acute and Continuing Care providers are expected to be in compliance with the requirements according to the timeframes listed below.
Long Term Care Facilities
(Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs))
Requirements for Reporting related to COVID-19
o CMS published an IFC (CMS-5531-IFC) requiring all LTC facilities report COVID-19 information using the Center for Disease Control (CDC) National Healthcare Safety Network (NHSN) (42 CFR 483(g)). Additionally, facilities are required to inform the residents, their representatives and families following the occurrence of either a single confirmed infection of COVID-19 or three or more residents or staff with new-onset of symptoms. This requirement to report information was extended through a final rule (CMS-1747-F) and is set to terminate on December 31, 2024, with the exception of the requirements at § 483.80(g)(1)(viii), which will

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 42 continue to be in effect as a requirement to support national efforts to control the spread of COVID-19. The reporting requirements referenced above also include provisions for reporting COVID-19 information to residents, their representatives and families (per 42 CFR 483.80(g)(3)). The CMS final rule that set reporting requirements to terminate on December 31, 2024 (CMS-1747) was released in November 2021, and at that time, this type of reporting was necessary. However, CMS is concerned that the effort required to continue this reporting provision may outweigh the utility of the information provided. For example, we have heard that providing families with the total number of cumulative COVID-19 cases (from June 2020) is not useful information. Additionally, this information is now publicly available on CMS' COVID-19 Nursing Home Data Website. Therefore, CMS is exercising enforcement discretion and will not expect providers to meet the requirements at 42 CFR 483.80(g)(3) at this time. All other reporting requirements referenced above remain in effect until December 31, 2024.	F 880		