STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495201	A. BUILDING _____ B. WING _____	C 10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSIDE HEALTH & REHAB CENTER	4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701

(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
E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 10/6/20 and continued offsite 10/7/20 through 10/9/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Surveyand a complaint investigation was conducted onsite on 10/6/20 and continued offsite 10/7/20 through 10/9/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The facility was in compliance with 42 CFR Part 483.80 infection control regulations. One complaint was investigated during the course of survey. The census in this 124 certified bed facility was 73 at the time of survey. A total of 73 residents were tested resulting in 35 confirmed case of COVID-19. A total of 77 staff members were tested resulting in 12 confirmed cases of COVID-19. There were 31 resident recoveries and 12 staff recoveries from COVID-19 at the time of survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kourtney Hales-Richardson	Administrator	10.27.2020

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 656	Continued From page 1 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to follow the comprehensive care plan for two of six Residents (Residents #4 and #6) in the survey sample.	F 656		

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F 656	Continued From page 2 1. For Resident #4, facility staff failed to followthe plan of care and obtain laboratory tests per physician's order on 9/3/20. 2. For Resident #6, facility staff failed to monitor and document food percentage intake per plan of care on several occasions in February and March of 2020. The findings included; 1. Resident #4 was admitted to the facility on 10/29/19 with diagnoses that included but were not limited to COVID-19, Type two diabetes, and unspecified protein calorie malnutrition. Resident #4's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/7/20. Resident #4 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status Exam). Review of Resident #4's clinical record revealed that she was diagnosed with COVID-19 on 8/27/20. The following note was documented by the physician on 9/3/20: "...(Name of Resident #4) was tested for COVID-19 on 8/27/20 -she was positive. She was transfer to Covid unit on all droplet precautions...Her sister is worried about her Covid positive results. I discussed with her detail that she does not have any severe symptoms at this time and we will continue to monitor her. I will send some blood work today..." Review of Resident #4's September 2020 POS (physician order summary) documented the following order: "CBC (Complete Blood Count) (1)	F 656	F 656 Develop/Implement Comprehensive Care Plan 1. For Resident #4, the community spoke with the resident's provider and received orders to obtain missed laboratory test from 09.03.2020. Resident #4 did not experience an adverse effect of the missed laboratory test. For Resident #6, the omitted documentation for food percentage could not be corrected as time has passed. 2. A 100% audit was completed on residents who received physician ordered laboratory test. No other residents were affected by this deficient practice. A 100 % audit was completed on monitoring and documenting food percentages per plan of care for residents. No other residents were affected by this deficient practice. 3. Current licensed nurses will be educated on following the plan of care as it relates to obtaining laboratory test per physician orders. Current nursing staff will be educated on monitoring and documenting food percentage intake per plan of care. 4. MDS Coordinator or designee will monitor resident care plans daily to ensure interventions are followed. DON or designee will monitor resident records weekly and as needed to ensure food percentage intake is documented per plan of care. Variances will be reviewed for patterns and/or trends, staff re-educated when deficient practice is identified and results reported to QAPI for input and guidance. Date of Compliance: 11.13.2020	

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F 656	Continued From page 3 , CMP (Complete Metabolic Panel) (2) , PT/INR (Prothrombin/International Normalized Ratio (3) , D-Dimer (4) one time only for 1 day. Status: Completed. Start date: 9/3/20. End date 9/4/20." Review of Resident #4's clinical record failed to reveal any evidence that the above test was completed. There was no copy of the results in Resident #4's clinical record. Resident #4's care plan dated 3/19/20 and revised on 10/9/20 documented the following: "Due to COVID-19 outbreak, the resident is at risk for infection r/t (related to) potential virus exposure and resident's current health status...Interventions: Labs and cultures as ordered." On 10/8/20 at 12:42 p.m., Resident #4's laboratory result from 9/3/20 was requested from ASM (Administrative Staff Member) #1, the facility Administrator. On 10/8/20 at 3:12 p.m., a telephone interview was conducted with ASM #1, the facility Administrator and ASM #2, the DON (Director of Nursing). When asked what they could determine about the 9/3/20 laboratory test for Resident #4; ASM #1 stated that that laboratory test was not done; that they could not find a requisition form for the lab or find the results in the laboratory computer system. ASM #1 stated, "Lab has no record." On 10/8/20 at approximately 1:00 p.m., a telephone interview was conducted with RN (Registered Nurse) #1. When asked the purpose of the care plan, RN #1 stated that the care plan was used as a guide for resident care. RN #1	F 656		

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F 656	Continued From page 4 stated that each individual care plan was resident specific to their needs. RN #1 stated that it is also updated with any changes in the resident's status. When asked if it was important for the care plan to be followed, RN #1 stated, "Oh yes." On 10/9/20 at 2:00 p.m., ASM #1 and ASM #2 were made aware of the above concerns. ASM #1 stated again that they did not have a requisition form for Resident #4's labs. Facility policy titled: "Comprehensive Care Planning" documents in part, the following: "An interdisciplinary plan of care will be established for every resident...All staff must be familiar with resident's Care Plan and all approaches must be implemented." No further information was presented prior to exit 1) CBC (Complete Blood Count) -"Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count tests measure the number and types of cells in your blood. This helps doctors check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders." This information was obtained from The National Institutes of Health. https://medlineplus.gov/bloodcounttests.html. (2) CMP (Complete Metabolic Panel) - "A CMP is used to check several body functions and processes, including: Liver and kidney health, Blood sugar levels, Blood protein levels, Acid and base balance, Fluid and electrolyte balance, Metabolism." This information was obtained from https://medlineplus.gov/lab-tests/comprehensive-	F 656		

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F 656	Continued From page 5 metabolic-panel-cmp/. (3) PT/INR (Prothrombin/International Normalized Ratio - "A prothrombin time (PT) test measures how long it takes for a clot to form in a blood sample. An INR (international normalized ratio) is a type of calculation based on PT test results. Prothrombin is a protein made by the liver. It is one of several substances known as clotting (coagulation) factors." This information was obtained from https://medlineplus.gov/lab-tests/prothrombin-time-test-and-inr-ptinr/. (4) D-Dimer -"A D-dimer test looks for D-dimer in blood. D-dimer is a protein fragment (small piece) that's made when a blood clot dissolves in your body." This information was obtained from: https://medlineplus.gov/lab-tests/d-dimer-test/#:~:text=D%2Ddimer%20is%20a%20protein,once%20your%20injury%20has%20healed. 2. For Resident #6, facility staff failed to monitor and document food percentage intake per plan of care on several occasions in February and March of 2020. Resident #6 was admitted to the facility on 2/3/20 with diagnoses that included but were not limited to surgical aftercare following surgery on the GI (gastrointestinal system), umbilical hernia with obstruction, unspecified protein-calorie malnutrition, diabetes type two and dysphagia (difficulty swallowing). Resident #6's most recent MDS (minimum data set) prior to discharge on 3/17/20; was an admission assessment with an ARD (assessment reference date) of 2/10/20. Resident #6 was coded as being moderately	F 656		

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F 656	Continued From page 6 impaired in cognitive function scoring 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #6's clinical record revealed a note by the Dietitian on 2/4/20 that documented the following: "Food and Fluid Intake % (Percentage) Breakfast 25-50 %, Lunch 25-50 %, Dinner 25 -50 % Food preferences were obtained. Weight Profile: H (height) 70.0 in (inches) lying down, W (weight) 176.8 lbs (pounds) Mechanical lift scale...Intake does not meet residents needs. poor to fair appetite...Goal: Diet/Supplements as ordered. Assist with meals as needed and monitor. Offer substitute if < (less than) 50 % (percent) consumed...monitor labs, weights and po (by mouth) intake for any undesired changes." Review of Resident #6's nutritional care plan dated 2/12/20 documented the following: "Resident has increased nutrition/hydration risk related to Dx (Diagnoses) w/documented (with) pressure areas, poor po- appetite stimulant in place. received mechanically altered diet secondary to Dx. dysphagia. Goal: Diet adequate in nutrition to aid in wound healing, weight maintenance, tolerate lest (sic) restrictive diet w/ (with) adequate po intake...Interventions: Monitor dietary intake (date initiated 2/12/20)... Offer alternate food if <50 % (percent) of meals. Review of Resident #6's February 2020 ADL (Activities of Daily Living) tracking form revealed several holes (blank spots) for the following dates under meal percentage for Eating: 2/11/20, 2/13/20, 2/15/20, 2/18/20, 2/19/20, 2/22/20, 2/23/20, 2/25/20, 2/27/20, 2/28/20, 2/30/20, 2/31/20. All three meals were not documented on	F 656		

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F 656	Continued From page 7 those dates. Review of Resident #6's March 2020 ADL tracking form revealed several holes for the following dates under meal percentage for Eating: 3/1/20, 3/5/20, 3/8/20 through 3/15/20; 3/18/20 through 3/21/20 and 3/23/20 through 3/30/20. All three meals were not documented on the those dates. On 10/8/20 at approximately 1 p.m., a telephone interview was conducted with RN (Registered Nurse) #1, a nurse familiar with Resident #6. When asked about resident #6's appetite, RN #1 stated that nursing staff would have to frequently encourage Resident #6 to eat. RN #1 stated that some days he was slower at eating than other days and that some days he would flat out refuse some meals. RN #1 stated that the family was aware of his poor appetite and that his intake was much better on days the sister would come in and sit with him. When asked what "holes" or blank spaces meant on the ADL flow sheet for eating, RN #1 stated that the nursing aides must have forgot to chart. RN #1 stated that the nursing aides usually documented meal percentage on the ADL flow sheet. RN #1 also stated that back in February and March of 2020 meals percentages were being documented on a paper chart. RN #1 stated that meal percentage was now being documented in the computer system and the system will alert nursing staff if documentation is not completed. RN #1 stated that the nurses were also supposed to go behind the nursing aides to ensure all documentation was being completed. When asked if she went behind her nursing aides to ensure complete and accurate documentation, RN #1 stated that MDS usually went behind them every month. RN#1	F 656		

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F 656	Continued From page 8 stated that she wasn't even aware that the nursing aides were not documenting on the ADL flow sheet. When asked how she was to monitor his meal intake if there were days of blank spaces on the ADL flow record, RN #1 stated that she was aware that Resident #6 had a poor appetite but there were never days of him refusing all three meals. RN #1 stated that Resident #6 would always eat something. RN #1 stated that the nursing aides would have alerted her if Resident #6 refused all meals and then she would have notified the physician. When asked how she would have offered alternate meals for an intake of less than 50 percent; if intake was not documented on the clinical record, RN #1 stated that she was not sure; that she may have been made aware verbally by the nursing aide. RN #1 could not recall that far back if any specific instances where she offered alternate food options to Resident #6. When asked the purpose of the care plan, RN #1 stated that the care plan was used as a guide for resident care. RN #1 stated that each individual care plan was resident specific to their needs. RN #1 stated that it is also updated with any changes in the resident's status. When asked if it was important for the care plan to be followed, RN #1 stated, "Oh yes." When asked if she could determine if intake was being monitored if it was not documented on the ADL flow sheets, RN #1 stated that she wasn't sure and could not recall that far back. RN #1 stated that intake should have been documented. On 10/9/20 at 2:00 p.m., ASM #1, the facility Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns. No further information was presented prior to exit.	F 656		

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F 684 SS=G	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 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 staff interview, medical record review, facility documentation review, and in the course of a complaint investigation, the facility stafffailed to provide treatment and services for the management of a diabetic resident, that led to a hyperglycemic episode with a blood glucose (sugar)* level of over 600 on 3/17/20 which required hospitalization constituting harm for one of six residents in the survey sample, Resident #6. A plan of correction previously put into place by the facility was reviewed and accepted, therefore this harm level deficiency is cited as past non-compliance. The findings included; Resident #6 was admitted to the facility on 2/3/20 with diagnoses that included but were not limited to surgical aftercare following surgery on the GI (gastrointestinal system), umbilical hernia with obstruction, unspecified protein-calorie malnutrition, diabetes type two and dysphagia (difficulty swallowing). Resident #6's most recent MDS (minimum data set) prior to discharge on 3/17/20; was an admission assessment with an ARD (assessment reference date) of 2/10/20.	F 684	Past noncompliance: no plan of correction required.	

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F 684	Continued From page 10 Resident #6 was coded as being moderately impaired in cognitive function scoring 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #6's clinical record revealed that he was admitted to the facility on 2/3/20 with sliding scale insulin and Accuchecks (blood sugar checks). The following order was in place on 2/3/20: "Humalog (1) Solution 100 unit/ml Inject per sliding scale if 151-199 = 3 units SQ (subcutaneous-under the skin); 200-249 = 6 units SQ; 250-299= 9 units SQ; 300-349 = 12 units; subcutaneously before meals and at bedtime for diabetes." This order for sliding scale insulin was d/c'd (discontinued on 2/11/20) by the Physician Assistant (PA). There was no evidence that Resident #6 was placed on any Accuchecks (blood sugar checks) after his sliding scale insulin was discontinued. Further review of Resident #6's February 2020 MAR (Medication Administration Record) revealed on 2/11/20 (last day of Accuchecks) Resident #6 did not require insulin at 8:00 a.m. and 11:30 a.m. The following note was documented by the Physician Assistant on 2/16/20 as a late entry for 2/11/20 "Following up today regarding repeat labs including BMP (2), CBC (3), liver function studies...BMP (basic metabolic panel) significant for persistently elevated creatinine (4) of 2.53 (previously 2.35), BUN (blood urea nitrogen) (5) 34, potassium 4.8, sodium 141, glucose 128 mg/dL... Blood glucose is range from 99 to 216 mg/dL, averaging in the 150s to 160s most days...Repeat BMP, CBC...STAT (immediately) due to worsening renal function."	F 684		

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F 684	Continued From page 11 Further review of Resident #6's POS (physician order summary) revealed the following lab orders initially ordered on 2/17/20; with a start date of 2/24/20; "CBC and BMP" one time only." This laboratory test was documented as completed on 2/25/20. Review of Resident #6's laboratory test (BMP) dated 2/25/20; revealed Resident #6 had a blood glucose level of 317. This laboratory test was not signed by the physician until 4/2/20 which was after the resident was discharged to the hospital on 3/17/20. Review of a nursing note dated 3/17/20 documented the following: "Resident appears lethargic. Blood Sugar check, result HI. (Name of PA) at facility. Resident evaluated by (Name of PA), order received to send resident to ER (Emergency Room). Report given to ER." A note documented by the PA on 3/17/20 documented the following: "ED (emergency department) transfer: Acutely altered mental status, critical hyperglycemia (high blood sugar), tachycardia (elevated pulse)...Nursing staff reports at the patient's mental status has been declining over the past several days. He has become more lethargic and is refusing medications. He sleeps most of the day and his PO (by mouth) intake has been poor. His family took him to a doctors appointment yesterday and noticed that he seemed sluggish and lethargic. Blood glucose was checked today and was greater than 600. It was reassessed after 30 minutes and was still reading as greater than 600. He has a diagnosis of diet controlled type II diabetes, with A1c (6) 5.4 % February 2020. Most	F 684		

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recent spot blood glucose check was performed three weeks ago was 130 mg/dL. He was not having his blood glucose checked regularly since he had remained well-controlled and was not taking any medications. Most recent labs performed 2/25 including BMP were accessed online today and reviewed. This was significant for elevated creatinine of 1.62 (sic, creatinine was 1.65 on 2/25 result), BUN 33 (sic; BUN was 22 on 2/25 result), potassium 3.7, sodium 141, glucose 317 mg/dL. It does not appear that any providers were made aware of these lab results, or that elevated glucose was addressed at that time, as the lab results were not scanned into his chart. On examination today, the patient is lying in bed in an obtunded state. Strong ketone (7) odor noted on his breath. Unable to wake patient up with sternal rub or verbal stimuli...pulse is mildly tachycardic at 103 bpm...Due to significant change in mentation, critical hyperglycemia of greater than 600 mg/dL, and tachycardia, patient is being sent via 911 to the emergency room now..."

Review of Resident #6's comprehensive care plan for Diabetes documented the following on 2/27/20: "The resident has diabetes mellitus...The resident will have no complications related to diabetes through next review date. .. labs as ordered by doctor contact md (medical doctor) with any abnormalities. "

A late entry note by the Physician's Assistant on 3/19/20 for 2/11/20 documented the following: "Late Entry Note: Note Text Addendum: Based on BG (blood sugar) reading remaining well controlled (150s-160s average) and HA1c of 5.4 %, sliding scale insulin as monotherapy is not recommended (Based on ADA (American

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F 684	Continued From page 13 Diabetes Association)... guidelines). Therefore, sliding scale insulin will be discontinued but Accuchecks should continue to be monitored regularly. Repeat BMP scheduled for 2/16/20." Review of Resident #6's hospital records was conducted. The History and Physical dated 3/17/20 documented the following: "...brought from nursing home for altered mental status and hyperglycemia. Hyperosmolar Hyperglycemic (8) state, Altered mental status; likely secondary to the above; Acute on chronic Stage IV (four) renal failure; likely secondary to the above, Leukocytosis (elevated white blood cells); could be secondary to the above; rule out sepsis (infection)...he was brought from nursing home for being altered and less responsive. Blood sugar read high, above the limit...In the ED his glucose was found above 1100 and with Leukocytosis of 20. He received IV (intravenous) fluids, IV insulin, empiric antibiotics...and is admitted for further management...3/17/20 at 3:49 p.m., H and P Labs...Glucose 1,158 (HH)...BUN 68 (H) (high)...Creatinine 3.51 (H)...Hemoglobin A1c 8.9 (H) est (estimated average glucose) 209." Review of the hospital discharge summary dated 3/24/20 documented the following: "Discharge Diagnoses: 1. Hyperosmolar Hyperglycemia state, much better. 2. Acute on chronic metabolic encephalopathy (9), now resolved. 3. Acute on Stage IV chronic kidney disease...4. Leukocytosis, resolved..." On 10/8/20 at 12:07 p.m., an interview was conducted with ASM (Administrative Staff Member) #4, the Physician Assistant. ASM #4 stated that she had discontinued Resident #6's	F 684		

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F 684	Continued From page 14 SSI (sliding scale insulin) because his blood sugar had been stable and his HA1c was within normal limits on his last drawn laboratory test prior to 2/11/20. ASM #4 stated, "If you look at the ADA guidelines, there was no indication for Accuchecks and SSI (sliding scale insulin)." ASM #4 stated that she usually writes an order to continue blood sugar checks for a few weeks after sliding scale insulin is discontinued for her diabetic residents. ASM #4 stated that staff did not continue to monitor his blood sugar levels; but that it was not indicated per ADAguidelines. When asked how ASM #4 conveys orders to the nursing staff, ASM #4 stated that most of the time, she will discontinue and input orders directly into the computer system herself. ASM #4 stated, "I find that doing it myself is necessary." When asked if she could recall inputting Resident #6's orders to d/c (discontinue) sliding scale insulin or if she gave the order to the nurse; ASM #4 stated that she could not recall. ASM #4 stated that it was her intention to have nursing staff monitor Resident #6's blood sugar levels after sliding scale insulin was discontinued. ASM #4 then stated that nursing staff also failed to make any providers aware of a critical glucose level on his 2/25/20 BMP test. ASM #4 stated that the elevated glucose was at a level of 329 (sic; sugar was actually at 317). ASM #4 stated that if she had seen that elevated blood sugar, she would have ordered additional monitoring at that time. When asked if the failure to continue blood sugar checks and the failure to report a critical lab caused Resident #6 harm; ASM #4 stated that she couldn't say; that if she had monitored Resident #6's blood sugars after the critical lab it probably would have been for a week or two anyway. When asked if she could have possibly seen a trend of sugar readings and ordered some	F 684		

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sort of medication/treatment for the management of his type two diabetes, ASM #4 stated that she couldn't say; that she wasn't sure the cause of his blood sugars being elevated because Resident #6 was discharged to the hospital on 3/17/20 and did not access to his hospital records. ASM #4 stated that Resident #6 may have had an infection; that she recalled the wound care physician saying his Stage 4 sacral ulcer was infected.

Review of Resident #6's 3/17/20 wound care note and hospital records failed to evidence any infected wounds.

On 10/8/20 at approximately 1:00 p.m., a telephone interview was conducted with RN (Registered Nurse) #1. When asked the process for obtaining ordered laboratory tests, RN #1 stated that once the physician orders the laboratory test, nursing will create lab slips or a requisition form and put it into the lab book. RN #1 stated that laboratory tests are drawn in the early morning on 11-7 shift by the laboratory technician. RN #1 stated that the laboratory technician will check the lab book prior to drawing blood to determine which residents need lab work. RN #1 stated that once the lab tests is obtained, the nurse will document on the MAR/TAR (Medication Administration Record or Treatment Administration Record) that it was completed. When asked how nurses know to follow up on a laboratory test that was recently drawn, RN #1 stated that nurses should get the information in report, and then they would follow up on the lab. RN #1 stated that the nurses can check the lab book to see if the technician had drawn the lab and can also check the laboratory computer system for the result. RN #1 stated that

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F 684	Continued From page 16 laboratory tests were usually faxed to the nursing station and if they receive an abnormal lab, they would immediately call the physician. RN #1 stated that from there, the physician would give orders; the nurses then file the lab into a communication book for the MD (Medical Doctor). When asked if nurses should document that the laboratory test was obtained and results were reviewed; or if the physician was made aware of an abnormal lab result, RN #1 stated, "Me, personally will also do a nurse's note." When asked if the laboratory results were scanned into the electronic medical record once the results were reviewed by the physician, RN #1 stated that another staff member usually scanned laboratory results into the computer system. RN #1 could not recall the staff member responsible for scanning in lab results. RN #1 stated that the results that are scanned into the electronic health record have to be signed by the physician first. On 10/8/20 at 1:38 p.m., further interview was conducted with ASM #4 the PA. ASM #4 stated that she did recall discontinuing the insulin order herself. ASM #4 stated that she forgot to write an additional order for blood sugar checks. ASM #4 stated that when the facility was owned by a previous company; Accuchecks and sliding scale orders were separate orders. ASM #4 stated that Resident #6's Accucheck orders were attached to the sliding scale orders so when she discontinued sliding scale insulin Accuchecks were also discontinued. ASM #4 stated that she assumed Resident #6 had a separate order for Accuchecks already in the system. ASM #4 stated that that was her mistake however the critical glucose level should have been reported to the providers immediately and addressed. When asked how she determined that facility staff failed to report	F 684		

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F 684	Continued From page 17 the critical glucose test to any providers; ASM #4 stated that on 3/17/20, when she assessed Resident #6, she noticed that his breath smelled of ketones and he was in a coma like state. ASM #4 went back to Resident #6's chart to look at recent labs and noticed the lab that was ordered for 2/25/20 was not in his clinical record. ASM #4 then stated that she had to look up the lab in the laboratory system and found the elevated glucose level. ASM #4 then stated that she went back to Resident #6's clinical record to see what his Accuchecks had been running and realized that no one was monitoring his blood sugar levels after the insulin was discontinued. On 10/8/20 at approximately 5:00 p.m., ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the potential for harm. Any additional information was requested at this time. On 10/9/20 at approximately at 1:17 p.m., ASM #1 and ASM #3, the corporate nurse provided a plan of correction that had been started in response to Resident #6's hyperglycemic episode. The following was documented: "1. On 3/17/20, resident, (Name of Resident #6) was sent out by ambulance to the hospital for a high blood sugar. The physician's assistant was in the facility and assessed him and sent him to the ER. The responsible party for the resident was notified. 2. The facility conducted a 100 percent audit of current residents with a diagnosis of Diabetes to identify others who may not have had their blood sugars checked or who did not have a clear order	F 684		

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F 684	Continued From page 18 for blood sugar checks. Completed 3/31/20. The facility provided education to the physician (Medical Director), NP (Nurse Practitioner), and the PA (Physician's Assistant) on ordering and clarifying when blood sugars are to be checked. Completed via phone 4/2/20. Standing orders for blood sugars monitoring was put into place. 4/1/20. 3. Education was provided for the licensed nursing staff by the DON (Director of Nursing) and RDCS (Regional Director of Clinical Services) on Diabetes, Blood Glucose monitoring and follow through. Began 4/1/20. The education will also be provided to new hires during orientation. 4. Audit daily (M-F) of new admissions with a diagnosis of Diabetes to ensure blood glucose protocol has been ordered and is correct by the DON x 3 months. Audit daily (M-F) of new orders which may require blood glucose monitoring to ensure that blood glucose was scheduled correctly by DON or designee x 3 months. 5. 4/6/2020" Review of the facility audits and education revealed that the above plan of correction was implemented by facility staff. Further review of the education revealed that staff were also educated on reporting abnormal laboratory tests to the physician or provider on 3/28/20, 3/31/20, and 4/2/20. Facility Policy titled, "Diabetic Protocol" documents in part, the following: "The provider and staff will work together to give the appropriate treatment to manage diabetes.	F 684		

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F 684	Continued From page 19 ...the nurse shall assess/document and report the following: -Any signs and symptoms of infection (urine, skin/wound, upper respiratory etc.) or other acute illnesses; -Change in intake/thirst; -Neurological changes such as changes in level of consciousness or orientation; - Resident's age and gender; -Resident's blood sugar history over 48 hours. -Usual patterns (fluctuations, trends) of blood sugars over recent months; -Approximate intake over 24 hours; -Current medications; -Dose and time of most recent hyperglyemic agent given; -Recent labs.... e. Based on the preceding assessment, including cause and complications, the provider may order further interventions, which may include: treatment of underlying conditions causing impaired glucose tolerance; Diet and lifestyle modifications where feasible and accepted by the resident; Oral hypoglycemic agents and/or f. The provider will follow up on any acute episodes associated with a significant blood glucose level changes and deterioration of previous glucose control and document resident's status at subsequent visits until the acute situation is resolved. g.the provider will order desired parameters for monitoring and reporting information related to diabetes and blood sugar management. The staff will incorporate such parameters into the Medication Administration Record and care plan. " Complaint deficiency.	F 684		

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F 684	Continued From page 20 *Blood Glucose- "The amount of glucose ("sugar", measured in mg/dL) in your blood changes throughout the day and night. Your levels will change depending upon when, what and how much you have eaten, and whether or not you have exercised. Normal Blood Sugars normal fasting (no food for eight hours) blood sugar level is between 70 and 99 mg/dL. A normal blood sugar level two hours after eating is less than 140 mg/dL. Diabetes is diagnosed by any one of the following: Two consecutive fasting blood glucose tests that are equal to or greater than 126 mg/dL. Any random blood glucose that is greater than 200 mg/dL. An A1c test that is equal to or greater than 6.5 percent. A1c is an easy blood test that gives a three month average of blood sugars. A two-hour oral glucose tolerance test with any value over 200 mg/dL." This information was obtained from https://www.virginiamason.org/whatarenormalblo odglucoselevels. (1) Humalog- rapid acting insulin used to lower blood sugar. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf m?setid=ce8354f4-bf07-4923-8755-47f3163662e 4 (2) BMP (Basic Metabolic Panel) - "A BMP is used to check several body functions and processes in the body. A BMP gives your doctor information about blood urea nitrogen (BUN), or how much nitrogen is in your blood to measure kidney function, creatinine, another indicator of kidney function, glucose, or blood sugar(having high or low blood sugar could both indicate pancreatic issues), carbon dioxide (CO2), or bicarbonate, a gas that can indicate issues with	F 684		

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F 684	Continued From page 21 your kidneys or lungs, calcium, which can indicate bone, kidney, or thyroid issues (though sometimes not included in a BMP), sodium and potassium, minerals that indicates your body ' s overall fluid balance, chloride, an electrolyte that indicates fluid balance." This information was obtained from The National Institutes of Health. https://www.healthline.com/health/cmp-vs-bmp. (3) CBC (Complete Blood Count) -"Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count testsmeasure the number and types of cells in your blood. This helps doctors check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting problems, blood cancers, and immune system disorders." This information was obtained from The National Institutes of Health. https://medlineplus.gov/bloodcounttests.html. (4) Creatinine-"is a waste product made by your muscles as part of regular, everyday activity. Normally, your kidneys filter creatinine from your blood and send it out of the body in your urine. If there is a problem with your kidneys, creatinine can build up in the blood and less will be released in urine. If blood and/or urine creatinine levels are not normal, it can be a sign of kidney disease." This information was obtained from https://medlineplus.gov/lab-tests/creatinine-test/. (5) BUN (Blood, Urea, Nitrogen) - "Urea nitrogen is what forms when protein breaks down. A test can be done to measure kidney function by the amount of urea nitrogen in the blood." This information was obtained from https://medlineplus.gov/ency/article/003474.htm.	F 684		

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F 684	Continued From page 22 (6) Hemoglobin HA1c- "The test results give you a picture of your average blood sugar level over the past two to three months. The higher the levels, the greater your risk of developing diabetes complications. The goal for most adults with diabetes is an HA1c that is less than 7%. HA1c test results are reported as a percentage. The higher the percentage, the higher your blood sugar levels over the past two to three months." This information was obtained from https://www.diabetes.org/a1c. (7) Ketone - "are chemicals that build up when your body starts to burn fat for energy. The most common cause of ketones in diabetics is insulin deficiency. Without enough insulin, glucose builds up in the blood stream and can't enter cells. The cells then burn fat instead of glucose." This information was obtained from https://beyondtype1.org/ketones. (8) Hyperosmolar Hyperglycemia- "A serious complication of diabetes mellitus, hyperosmolar hyperglycemic syndrome (HHS) happens when blood sugar levels are very high for a long period of time. Symptoms of HHS can include extreme thirst, frequent urination, changes in your vision and confusion. HHS is an emergency..." This information was obtained from https://my.clevelandclinic.org/health/diseases/21147-hyperosmolar-hyperglycemic-syndrome. (9) Metabolic encephalopathy- "result from systemic illness, such as diabetes, liver disease, renal failure and heart failure Metabolic encephalopathies usually develop acutely or subacutely and are reversible if the systemic disorder is treated. If left untreated, however, metabolic encephalopathies may result in	F 684		

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F 684	Continued From page 23 secondary structural damage to the brain." This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK20383/.	F 684		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that facility staff failed to obtain a laboratory test on 9/3/20 per physician's order for one of six residents, Resident #4, in the survey sample. The findings included; Resident #4 was admitted to the facility on 10/29/19 with diagnoses that included but were not limited to COVID-19, Type two diabetes, and unspecified protein calorie malnutrition. Resident #4's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/7/20. Resident #4 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status Exam).	F 770	F 770 Laboratory Services 1. For Resident #4, the community spoke with the resident's provider and received orders to obtain missed laboratory test from 09.03.2020. Resident #4 did not experience an adverse effect of the missed laboratory test. 2. A 100% audit was completed on residents who received physician ordered laboratory test. No other residents were affected by this deficient practice. 3. Current licensed nurses will be educated on following the plan of care as it relates to obtaining laboratory test per physician orders. 4. DON or designee will monitor resident records weekly and as needed to ensure physician ordered laboratory tests are obtained. Variances will be reviewed for patterns and/or trends, staff re-educated when deficient practice is identified and results reported to QAPI for input and guidance. Date of Compliance: 11.13.2020	

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PORTSIDE HEALTH & REHAB CENTER	4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701

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F 770	Continued From page 24 Review of Resident #4's clinical record revealed that she was diagnosed with COVID-19 on 8/27/20. The following note was documented by the physician on 9/3/20: "...(Name of Resident #4) was tested for COVID-19 on 8/27/20 -she was positive. She was transfer to Covid unit on all droplet precautions...Her sister is worried about her Covid positive results. I discussed with her detail that she does not have any severe symptoms at this time and we will continue to monitor her. I will send some blood work today..." Review of Resident #4's September 2020 POS (physician order summary) documented the following order: "CBC (Complete Blood Count) (1) , CMP (Complete Metabolic Panel) (2) , PT/INR (Prothrombin/International Normalized Ratio (3) , D-Dimer (4) one time only for 1 day. Status: Completed. Start date: 9/3/20. End date 9/4/20." Review of Resident #4's clinical record failed to reveal any evidence that the above test was completed. There was no copy of the results in Resident #4's clinical record. Resident #4's care plan dated 3/19/20 and revised on 10/9/20 documented the following: "Due to COVID-19 outbreak, the resident is at risk for infection r/t (related to) potential virus exposure and resident's current health status...Interventions: Labs and cultures as ordered." On 10/8/20 at 12:42 p.m., Resident #4's laboratory result from 9/3/20 was requested from ASM (Administrative Staff Member) #1, the facility Administrator. On 10/8/20 at 12:43 p.m., ASM #1 stated that he	F 770		

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F 770	Continued From page 25 did not have laboratory results for Resident #4 on 9/3/20. On 10/8/20 at approximately 1:00 p.m., a telephone interview was conducted with RN (Registered Nurse) #1. When asked the process for obtaining ordered laboratory tests, RN #1 stated that once the physician orders the laboratory test, nursing will create lab slips or a requisition form and put it into the lab book. RN #1 stated that laboratory tests are drawn in the early morning on 11-7 shift by the laboratory technician. RN #1 stated that the laboratory technician will check the lab book prior to drawing blood to determine which residents need lab work. RN # stated that once the lab tests is obtained, the nurse will document on the MAR/TAR (Medication Administration Record or Treatment Administration Record) that it was completed. When asked how nurses know to follow up on a laboratory test that was recently drawn, RN #1 stated that nurses should get the information in report, and then they would follow up on the lab. RN #1 stated that the nurses can check the lab book to see if the technician had drawn the lab and can also check the laboratory computer system for the result. RN #1 stated that laboratory tests were usually faxed to the nursing station. RN#1 that if they receive an abnormal lab; they would immediately call the physician. RN #1 stated that from there, the physician would give orders. RN #1 stated that the nurses then file the lab into a communication book for the MD (Medical Doctor). When asked if nurses should document that the laboratory test was obtained and results were reviewed; or if the physician was made aware of an abnormal lab result, RN #1 stated, "Me, personally will also do a nurse's note." When asked if the laboratory resultswere	F 770		

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F 770	Continued From page 26 scanned into the electronic medical record once the results were reviewed by the physician, RN #1 stated that another staff member usually scanned laboratory results into the computer system. RN #1 could not recall the staff member responsible for scanning in lab results. RN #1 stated that the results that are scanned into the electronic health record have to be signed by the physician first. On 10/8/20 at 3:12 p.m., a telephone interview was conducted with ASM #1, the facility Administrator and ASM #2, the DON (Director of Nursing). When asked what they could determine about the 9/3/20 laboratory test for Resident #4; ASM #1 stated that that laboratory test was not done; that they could not find a requisition form for the lab or find the results in the laboratory computer system. ASM #1 stated, "Lab has no record." When asked why the lab was not completed, ASM #2 stated that she had a call placed out to the nurse (Licensed Practical Nurse-LPN #2) who documented that the laboratory test was completed. This writer also asked to talk to LPN #2. On 10/9/20 at 10:57 a.m., an interview was conducted with LPN #2, the nurse who signed that the 9/3/20 lab was completed. LPN #2 stated that Resident #4 was on the COVID hall on 9/3/20 due to her COVID positive status. LPN #2 stated that nursing staff assigned to the COVID hall are not allowed to access the rest of the building or the nurses station. LPN #2 stated that when she saw the order for the CBC, CMP, D-Dimer etc. to be drawn on Resident #4; she called over to the Unit 2 nursing station and asked the nurse on the unit to make lab slips for Resident #4's 9/3/20 labs. LPN #2 could not recall the nurse she had spoken to. LPN #2 stated that the lab technician	F 770		

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F 770	Continued From page 27	F 770		

was supposed to draw labs on the COVID side last. LPN #2 stated that because she can only stay on the COVID hallway; she could not check if a requisition form had been created or if the lab technician had signed off in the lab book that she was going to draw Resident #4's labs on 9/4/20. LPN #2 stated that the laboratory technician usually arrives early in the morning to draw labs, the day after the lab is ordered. LPN #2 stated that she documented Resident #4's labs as completed because once she saw the order, she notified the nurse at the nursing station to create lab slips. LPN #2 stated that if she didn't mark the lab as completed, the lab could have possibly been drawn twice on Resident #4.

On 10/9/20 at 2:00 p.m., ASM #1 and ASM #2 were made aware of the above concerns. ASM #1 stated again that they did not have a requisition form for Resident #4's labs. No further information was presented prior to exit. ASM #1 stated that the facility did not have a policy on obtaining labs. ASM #1 was able to present a policy regarding following physician's orders.

Facility policy titled, "Physician's Orders" documented in part, the following: "The Charge Nurse shall transcribe and review all physician's orders in order to effect their implementation ."

No further information was presented prior to exit.

(1) CBC (Complete Blood Count) -"Your blood contains red blood cells (RBC), white blood cells (WBC), and platelets. Blood count tests measure the number and types of cells in your blood. This helps doctors check on your overall health. The tests can also help to diagnose diseases and conditions such as anemia, infections, clotting

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F 770	Continued From page 28 problems, blood cancers, and immune system disorders." This information was obtained from The National Institutes of Health. https://medlineplus.gov/bloodcounttests.html. (2) CMP (Complete Metabolic Panel) - "A CMP is used to check several body functions and processes, including: Liver and kidney health, Blood sugar levels, Blood protein levels, Acid and base balance, Fluid and electrolyte balance, Metabolism." This information was obtained from https://medlineplus.gov/lab-tests/comprehensive-metabolic-panel-cmp/. (3) PT/INR (Prothrombin/International Normalized Ratio - "A prothrombin time (PT) test measures how long it takes for a clot to form in a blood sample. An INR (international normalized ratio) is a type of calculation based on PT test results. Prothrombin is a protein made by the liver. It is one of several substances known as clotting (coagulation) factors." This information was obtained from https://medlineplus.gov/lab-tests/prothrombin-time-test-and-inr-ptinr/. (4) D-Dimer -"A D-dimer test looks for D-dimer in blood. D-dimer is a protein fragment (small piece) that's made when a blood clot dissolves in your body." This information was obtained from: https://medlineplus.gov/lab-tests/d-dimer-test/#:~:text=D%2Ddimer%20is%20a%20protein,once%20your%20injury%20has%20healed.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5)Resident-identifiable information. (i) A facility may not release information that is	F 842		

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F 842	Continued From page 29 resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical	F 842		

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F 842	Continued From page 30 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to document meal percentage intake at every meal on the February and March 2020 ADL (Activities of Daily Living) flow sheets for one of six sampled residents, Resident #6. The findings included; Resident #6 was admitted to the facility on 2/3/20 with diagnoses that included but were not limited to surgical aftercare following surgery on the GI (gastrointestinal system), umbilical hernia with obstruction, unspecified protein-calorie	F 842	F 842 Resident Records – Identifiable Information 1. For Resident #6, the omitted documentation for food percentage could not be corrected as time has passed. Resident #6 did not experience adverse effects as a result of this deficient practice. 2. A 100% audit was completed on resident's ADL documentation to ensure staff documented meal percentage intake at every meal. No other residents were affected by this deficient practice. 3. Current licensed nursing staff will be educated on documenting resident's meal percentage intake at every meal. 4. DON or designee will monitor resident records bi-weekly and as needed to ensure meal percentage is documented at every meal. Variances will be reviewed for patterns and/or trends, staff re-educated when deficient practice is identified and results reported to QAPI for input and guidance. Date of Compliance: 11.13.2020	

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F 842	Continued From page 31 malnutrition, diabetes type two and dysphagia (difficulty swallowing). Resident #6's most recent MDS (minimum data set) prior to discharge on 3/17/20; was an admission assessment with an ARD (assessment reference date) of 2/10/20. Resident #6 was coded as being moderately impaired in cognitive function scoring 11 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #6's clinical record revealed a note by the Dietitian on 2/4/20 that documented the following: "Food and Fluid Intake % (Percentage) Breakfast 25-50 %, Lunch 25-50 %, Dinner 25 -50 % Food preferences were obtained. Weight Profile: H (height) 70.0 in (inches) lying down, W (weight) 176.8 lbs (pounds) Mechanical lift scale...Intake does not meet residents needs. poor to fair appetite...Goal: Diet/Supplements as ordered. Assist with meals as needed and monitor. Offer substitute if < (less than) 50 % (percent) consumed...monitor labs, weights and po (by mouth) intake for any undesired changes." Review of Resident #6's nutritional care plan dated 2/12/20 documented the following: "Resident has increased nutrition/hydration risk related to Dx (Diagnoses) w/documented (with) pressure areas, poor po- appetite stimulant in place. received mechanically altered diet secondary to Dx. dysphagia. Goal: Diet adequate in nutrition to aid in wound healing, weight maintenance, tolerate lest (sic) restrictive diet w/ (with) adequate po intake...Interventions: Monitor dietary intake (date initiated 2/12/20)... Offer alternate food if <50 % (percent) of meals. Review of Resident #6's February 2020 ADL	F 842		

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F 842	Continued From page 32 (Activities of Daily Living) tracking form revealed several holes (blank spots) for the following dates under meal percentage for Eating: 2/11/20, 2/13/20, 2/15/20, 2/18/20, 2/19/20, 2/22/20, 2/23/20, 2/25/20, 2/27/20, 2/28/20, 2/30/20, 2/31/20. All three meals were not documented on those dates. Review of Resident #6's March 2020 ADL tracking form revealed several holes for the following dates under meal percentage for Eating: 3/1/20, 3/5/20, 3/8/20 through 3/15/20; 3/18/20 through 3/21/20 and 3/23/20 through 3/30/20. All three meals were not documented on the those dates. On 10/8/20 at approximately 1 p.m., an telephone interview was conducted with RN (registered nurse) #1, a nurse familiar with Resident #6. When asked about resident #6's appetite, RN #1 stated that nursing staff would have to frequently encourage Resident #6 to eat. RN #1 stated that some days he was slower at eating than other days and that some days he would flat out refuse some meals. RN #1 stated that the family was aware of his poor appetite and that his intake was much better on days the sister would come in and sit with him. When asked what "holes" or blank spaces meant on the ADL flow sheet for eating, RN #1 stated that the nursing aides must have forgot to chart. RN #1 stated that the nursing aides usually documented meal percentage on the ADL flow sheet. RN #1 also stated that back in February and March of 2020 meals percentages were being documented on a paper chart. RN #1 stated that meal percentage was now being documented in the computer system and the system will alert nursing staff if documentation is not completed. RN #1 stated	F 842		

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F 842	Continued From page 33 that the nurses were also supposed to go behind the nursing aides to ensure all documentation was being completed. When asked if she went behind her nursing aides to ensure complete and accurate documentation, RN #1 stated that MDS usually went behind them every month. RN #1 stated that she wasn't even aware that the nursing aides were not documenting on the ADL flow sheet. When asked how she was to monitor his meal intake if there were days of blank spaces on the ADL flow record, RN #1 stated that she was aware that Resident #6 had a poor appetite but there were never days of him refusing all three meals. RN #1 stated that Resident #6 would always eat something. RN #1 stated that the nursing aides would have alerted her if Resident #6 refused all meals and then she would have notified the physician. When asked how she would have offered alternate meals for an intake of less than 50 percent; if intake was not documented on the clinical record, RN #1 stated that she was not sure; that she may have been made aware verbally by the nursing aide. RN #1 could not recall that far back if any specific instances where she offered alternate food options to Resident #6. When asked if Resident #6's medical record was complete if there were several days of blank spaces under meal percentage; RN #1 stated, "No, it's not a complete medical record." Further review of Resident #6's clinical record revealed no concerns related to a significant weight loss. On 10/9/20 at 2:00 p.m., ASM #1, the facility Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.	F 842		

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F 842	Continued From page 34 Facility policy titled, "Record Retention," did not address the above concerns related to a complete medical record. No further information was presented prior to exit.	F 842		