STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495255	A. BUILDING _____ B. WING _____	C 10/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYVIEW SPRINGS REHAB AND NURSING CENTER	30 MONTVUE DRIVE LURAY, VA 22835

(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 from 10/19/2020 through 10/21/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The completion and submission of this credible allegation of compliance does not constitute an admission that the facility agrees with the allegations in the 2567. The facility is completing the allegation of compliance because it is required by state and federal law. The facility disagrees with and disputes the deficiencies as stated and the scope and severity at which they were cited. Further, the facility disputes and disagrees with the accuracy of statements and other information relied upon in support of the stated deficiencies. The facility reserves it's rights to dispute, appeal, and contest the stated deficiencies and take any action related to or arising therefrom in any other forum as needed.	
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted from 10/19/2020 through 10/21/2020. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 98. Of the 98 current residents, 2 residents were positive for the COVID-19 virus. The survey sample consisted of 12 current resident reviews (Residents #2, #3, #4, #5, #6, #7, #9, #10, #11, #12, #13 and #14) and 2 closed record reviews (Residents #1 and #8).	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580	1. Resident #7's Responsible Party was notified of incidents dated 5/14/20, 6/9/20, 6/13/20, and 10/2/20 on 10-30-20. Resident #7 is alert and oriented and does not want spouse to be notified of occurrences in the facility and her face sheet was updated on 10-27-20. All residents have potential to be affected by this practice	11-9-20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erica M. Miller — TITLE: Administrator — (X6) DATE: 10/30/20

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 580	Continued From page 1 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 580	2. An audit of all incidents since 10/1/20 was completed on 10-30-20, and all RP's have been notified of incidents 3. Licensed staff will be educated regarding RP notification by the Director of Nursing by 11-9-20. 4. The DON/Designee will audit incidents for RP notification 5x/week x 3 months. Any RP that has not been notified will be notified immediately and DON/Designee will provide 1:1 education with the nurse that failed to notify. 5. Results of this audit will be brought to QAPI by the DON for three months or until compliance is achieved. The members of the QAPI committee include the Medical Director/Designee, Administrator, Director of Nursing, Unit Managers, MDS, Business Office Manager, Social Services Director, Human Resources Director, Staffing Coordinator, Medical Records Coordinator, Therapy Manager, Admissions Director, Housekeeping Director, Maintenance Director, and a Certified Nursing Assistant	

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F 580	Continued From page 2 a complaint investigation, it was determined that the facility staff failed to notify a resident's RP (responsible party) of a change in condition for one of 14 residents in the survey sample, Resident #7. The facility staff failed to notify Resident #7's RP of the resident's falls that occurred on 5/14/20, 6/9/20, 6/13/20 and 10/2/20. The findings include: Resident #7 was admitted to the facility on 11/19/19. Resident #7's diagnoses included but were not limited to heart failure, diabetes and anxiety disorder. Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/6/20, coded the resident as being cognitively intact. Section J coded Resident #7 as having sustained one fall since the prior assessment. Review of Resident #7's clinical record face sheet revealed the resident's husband was listed as the RP. Review of Resident #7's clinical record (including nurses' notes and fall investigations) revealed the resident fell on 3/7/20, 5/14/20, 6/9/20, 6/13/20 and 10/2/20. Further review of nurses' notes and fall investigations for the above falls failed to reveal Resident #7's responsible party was notified of the falls on 5/14/20, 6/9/20, 6/13/20 and 10/2/20. On 10/20/20 at 1:42 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #8, the nurse caring for Resident #7 when she fell on 6/9/20. LPN #8 stated residents' RPs should be notified of falls. LPN #8 stated she does not notify RPs if the residents are alert,	F 580		

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F 580	Continued From page 3 oriented and make their own decisions. LPN #8 stated she knew she had talked to Resident #7's RP about her falls but she could not guarantee she notified the RP regarding Resident #7's fall on 6/9/20. LPN #8 stated sometimes Resident #7 will state that her husband is not home or she will tell him. On 10/21/20 at 11:01 a.m., a telephone interview was conducted with LPN #10, the nurse caring for Resident #7 when she fell on 6/13/20. LPN #10 stated residents' RPs should be notified of falls. LPN #10 stated she may not have called Resident #7's RP when the resident fell on 6/13/20 because the fall occurred early in the morning. LPN #10 stated she may have called the RP later and did not document this but she could not recall. On 10/21/20 at 12:43 p.m., a telephone interview was conducted with RN (registered nurse) #4, the nurse caring for Resident #7 when she fell on 10/2/20. RN #4 stated residents' RPs should be notified of falls. RN #4 stated she did not recall when Resident #7 fell on 10/2/20. On 10/21/20 at 4:00 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing) were made aware of the above concern. The facility policy titled, "Assessing Falls and Their Causes" documented, "Reporting: 1. Notify the following individuals when a resident falls: a. The resident's family..." No further information was presented prior to exit.	F 580		
F 602 SS=D	Free from Misappropriation/Exploitation	F 602		

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F 602	Continued From page 4 CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure one of 14 sampled residents, (Resident #1) was free from misappropriation of resident property. On 9/23/20 Resident #1's physician prescribed medication 30 count Oxycodone 5mg (milligrams), narcotic medication card and the associated sign out / count sheet was missing. The findings include: Resident #1 was admitted to the facility on 9/17/19 at expired at the facility on 10/19/19. The resident had diagnoses of but not limited to coronary bypass, pneumonia, multiple fractures, depression, diabetes, insomnia, high blood pressure, peripheral vascular disease, dysphagia, and oral/throat cancer. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/24/19 coded the resident as being mildly cognitively impaired to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for hygiene, toileting, dressing, and transfers; and supervision for	F 602	1. Resident #1 expired in the facility on 10/19/19. 2. An audit of narcotic counts was completed on 10-30-20, with all narcotic counts being correct. 3. Licensed staff will be educated by the DON/Designee regarding misappropriation of property (narcotic diversion) by 11-9-20. 4. DON or Designee will audit narcotic records on 5 residents 2x/week x 4 weeks, then weekly x 4 weeks to ensure counts are correct. 5. Results of this audit will be brought to QAPI by the DON for three months or until compliance is achieved. The members of the QAPI committee include the Medical Director, Administrator, Director of Nursing, Unit Managers, MDS, Business Office Manager, Social Services Director, Human Resources Director, Staffing Coordinator, Medical Records Coordinator, Therapy Manager, Admissions Director, Housekeeping Director, Maintenance Director, and a Certified Nursing Assistant	11-9-20

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F 602	Continued From page 5 eating. Review of a FRI (Facility Reported Incident) dated 9/23/19 documented (and faxed to the required state agency on 9/23/19 at 6:14 PM per the fax date stamp), "Describe incident, including location, and action taken: A card of (30) oxycodone (1) 5 mg (milligrams) is missing from narcotic lock up box." A follow up to the FRI, dated 9/27/20, documented, "This is the final written internal investigation report for the FRI for (Resident #1) that was reported on 9/23/19 for misappropriation of resident property. (Resident #1) is a 77-year old who was admitted on 09/17/19....On the morning of September 23, (2019) the day shift nurse (RN #2 - Registered Nurse) told the night nurse (LPN #1 - Licensed Practical Nurse) that a card of (Resident #1) narcotic medicine was missing. She informed the night nurse that he had 4 cards of oxycodone 5mg and now had 3 cards and that she was not taking the cart. She went to the DON (Director of Nursing) (RN #1) and told the DON that a card was missing. The DON told the day nurse that she would do an investigation on the missing medication and she proceeded to go do this, but the day nurse refused to take the cart and laid the keys on the DON desk and walked out. Investigation revealed that (Resident #1) had a total of 5 cards of oxycodone 5mg sent to the facility. Each card had its own count sheet with 30 count on each sheet. There were 4 cards left, one was being used and had 7 pills left in it and the count was correct. The other 3 remaining cards had been number 1 of 4, 3 of 4, and 4 of 4 and the card 2 of 4 was missing along with the count sheet. The DON questioned the night nurse who said that	F 602		

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F 602	Continued From page 6 she was unaware that there were 5 cards. She counted what was in the cart and found to be correct with what was there, the 3-11 nurse from 09/22 (2019) was questioned as well and she stated the same as the night nurse. The police were notified, and they will be doing an investigation into the missing oxycodone. The facility administration has found that a card of oxycodone 5mg (30 pills) is missing, the allegation of misappropriation of resident property is founded. The missing medication will be replaced. The police will be conducting the investigation and upon completion the findings will be forwarded to the (state agency). The facility has initiated a count sheet for all cards, count sheets and number of bottles will be counted each shift to ensure no further diversion of medications is taking place. The pharmacy has been notified and that they are to send count sheets with the total number of pills sent with multiply (sic) cards not to send individual count sheets with each card. IE: 120 pills would be on the initial count sheet instead of having 4 count sheets with 30 individual counts." A review of the pharmacy manifest revealed that on 9/17/19 a single card of oxycodone 5 mg tabs, 30 tabs (tablets), was delivered for Resident #1. Further review revealed that on 9/18/19, 4 cards of oxycodone 5 mg tabs, 30 tabs per card, was delivered for Resident #1. On the morning of 9/23/19 at the time of discovery that a card was missing, the resident had been administered 23 tabs of the 30 from the card delivered on 9/17/20, leaving 7 tabs left. A review of a copy of the card revealed it was marked "1 of 1" and was showing 7 pills left and the associated sign out / count sheet revealed	F 602		

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F 602	Continued From page 7 this count to be accurate. In addition, copies of three additional cards (marked as 1 of 4, 3 of 4 and 4 of 4) and associated sign out / count sheets revealed the resident had not received any of these tabs yet and the count reflected the cards to be full of all 30 tabs present. This is an accurate count for what was present in the drawer. There was no card marked "2 of 4." A review of the facility investigation revealed the following: RN #2 (Registered Nurse) did not have a written statement. RN #1 who was the DON [director of nursing] at the time, documented that RN #2, who worked day shift on 9/22/19 and 9/23/19, stated that on 9/22/19, there were 4 cards of the oxycodone and that now (morning of 9/23/19) there were only 3 cards. It was further documented in RN #1's written statement that in her interviews with the evening nurse from 9/22/19 (LPN #6 - Licensed Practical Nurse) stated that the narcotic count was correct when she took over from RN #2, as well as when she signed off the medication cart to the night nurse, LPN #1. LPN #6 also provided there was a written statement with LPN #6's name on it that documented as much. However LPN #6 did not write this statement nor sign it. This statement was written by the former DON (RN #1) of her alleged interview with LPN #6. There was a also a written statement for LPN #1 that documented that the narcotic count was correct when she took the cart from LPN #6 the night of 9/22/19 and when she counted with RN #2 the morning of 9/23/19. This written statement also documented that she recalled having "signed in 4 cards" of	F 602		

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F 602	Continued From page 8 oxycodone and that there was now one card missing. However LPN #1 did not write this statement or sign it. This statement was written by the former DON (RN #1) of her alleged interview with LPN #1. On 10/20/20 at 8:22 AM, LPN #1 was interviewed and she was not able to recall specifics of the incident. LPN #1 stated that she recalled that there was discussion of a card and sheet missing, but that she did not know what happened after that because she went on medical leave afterwards for surgery. When asked if she loaned the keys to another staff member who may have taken the card and sheet, LPN #1 stated she never does on her shift (night shift) as there is no one else there. RN #1, RN #2, and LPN #6 were all no longer employed at the facility and therefore could not be interviewed. On 10/21/20 at 3:20 PM an interview was conducted with ASM #1 and ASM #2 (Administrative Staff Member - the Administrator and Corporate Nurse, respectively). Both had been with the facility for approximately one month and were not aware of a drug diversion incident from 2019 until a request was made for the FRI on the incident. A review of the facility policy, "Controlled Substance Storage" documented, "E. At shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses and is documented....F. Any discrepancy in controlled substance counts is reported to the Director of Nursing immediately. The Director or	F 602		

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F 602	Continued From page 9 designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The Director of Nursing documents irreconcilable discrepancies in a report to the Administrator...." A review of the facility policy, "Abuse Policy" documented, "(Facility) will not tolerate Abuse, Neglect, Exploitation of its residents or the Misappropriation of Resident Property....Misappropriation of Resident Property: The deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent...." No further information was provided by the end of the survey. References: (1) Oxycodone is used to relieve moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609	1. Resident #1 expired in the facility on 10/19/20 2. DON or Designee will audit each facility reported incident to ensure that it is reported within 2 hours starting 10/27/20 3. Staff will be educated by DON/Designee on abuse reporting requirements to include the two hour time requirement by 11-9-20	11-9-20

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F 609	Continued From page 10 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to report an allegation of misappropriation of resident property, to the required state agency within the required 2 hour time frame, for one of 14 residents in the survey sample, Resident #1. The findings include: On 9/23/19 Resident #1's card of 30 count Oxycodone (1) 5mg (milligrams) narcotic medication and associated sign out / count sheet was identified as missing during the morning change of shift narcotic count between off-going night shift and on-coming day shift. The allegation was not reported until 6:14 PM that	F 609	4. DON/Designee will audit each facility reported incident to ensure that it is reported within 2 hours and staff will be immediately re-educated on reporting requirements if found to be greater than 2 hours ongoing. 5. Results of this audit will be brought to QAPI by the DON for three months or until compliance is achieved. The members of the QAPI committee include the Medical Director/Designee, Administrator, Director of Nursing, Unit Managers, MDS, Business Office Manager, Social Services Director, Human Resources Director, Staffing Coordinator, Medical Records Coordinator, Therapy Manager, Admissions Director, Housekeeping Director, Maintenance Director, and a Certified Nursing Assistant	

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F 609	Continued From page 11 evening, exceeding the 2 hour time frame by approximately 9 hours. Resident #1 was admitted to the facility on 9/17/19 at expired at the facility on 10/19/19. The resident had diagnoses of but not limited to coronary bypass, pneumonia, multiple fractures, depression, diabetes, insomnia, high blood pressure, peripheral vascular disease, dysphagia, and oral/throat cancer. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/24/19 coded the resident as being mildly cognitively impaired to make daily life decisions. Review of a FRI (Facility Reported Incident) dated 9/23/19 documented (and faxed to the required state agency on 9/23/19 at 6:14 PM per the fax date stamp), "Describe incident, including location, and action taken: A card of (30) oxycodone 5 mg (milligrams) is missing from narcotic lock up box." A follow up to the FRI, dated 9/27/20, documented, "This is the final written internal investigation report for the FRI for (Resident #1) that was reported on 9/23/19 for misappropriation of resident property. (Resident #1) is a 77-year old who was admitted on 09/17/19....On the morning of September 23, (2019) the day shift nurse (RN #2 - Registered Nurse) told the night nurse (LPN #1 - Licensed Practical Nurse) that a card of (Resident #1) narcotic medicine was missing. She informed the night nurse that he had 4 cards of oxycodone 5mg and now had 3 cards and that she was not taking the cart. She went to the DON (Director of Nursing) (RN #1) and told the DON that a card was missing. The DON told the day nurse that she would do an	F 609		

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F 609	Continued From page 12 investigation on the missing medication and she proceeded to go do this...." This follow up documented that the facility was aware of the incident during the morning hours after the nightshift and day shift nurse did the narcotic count for shift change. A review of the written statements revealed one written by RN #1, regarding her interview with LPN #1. The time written on this statement was 9/23/19 at 7:15 AM. This was during the time of shift change and indicated that as early as 7:15 AM the facility was aware of the allegation. The date stamp on the FRI that was submitted was 9/23/19 at 6:14 PM. This was approximately 11 hours after the incident and approximately 9 hours past the required 2 hour time frame for reporting an allegation of abuse. On 10/21/20 at 3:20 PM an interview was conducted with ASM #1 and ASM #2 (Administrative Staff Member - the Administrator and Corporate Nurse, respectively). Both had been with the facility for approximately one month and were not aware of a drug diversion incident from 2019 until a request was made for the FRI on the incident. However, ASM #2 stated that an allegation of abuse should be reported within 2 hours. A review of the facility policy, "Abuse Investigation and Reporting" documented, "....Reporting:....2. An alleged allegation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than: (1) Two (2) hours if the alleged violation involves abuse OR has resulted in	F 609		

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F 609	Continued From page 13 serious bodily injury; or b. Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury...." No further information was provided by the end of the survey. References: (1) Oxycodone is used to relieve moderate to severe pain. Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html	F 609		
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 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,	F 842	1. Resident #8 no longer resides at this facility. Any resident is at risk of this practice 2. An audit of resident shower orders will be completed to ensure that the orders are set up to allow documentation to be completed on non scheduled shower days by 10-27-20. An audit of insulin administration orders will be completed by 10-30-20 to ensure parameters are ordered. 3. DON or Designee will educate nursing staff on the requirement for showers at least twice a week and on how to document showers given on non scheduled shower days by 11-9-20. DON or Designee will educate licensed staff on having complete and accurate documentation regarding insulin administration by 11-9-20.	11-9-20

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F 842	Continued From page 14 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 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	F 842	4. Don or Designee will audit showers provided weekly x 8 weeks to ensure residents have complete shower documentation. DON or Designee will audit Medication Administration orders weekly x 8 weeks to ensure insulin administration has been documented as per parameters 5. Results of this audit will be brought to QAPI by the DON for three months or until compliance is achieved. The members of the QAPI committee include the Medical Director/Designee, Administrator, Director of Nursing, Unit Managers, MDS, Business Office Manager, Social Services Director, Human Resources Director, Staffing Coordinator, Medical Records Coordinator, Therapy Manager, Admissions Director, Housekeeping Director, Maintenance Director, and a Certified Nursing Assistant	

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F 842	Continued From page 15 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, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 14 residents in the survey sample, Resident #8. 1. The facility staff failed to document showers/baths that were provided for Resident #8 on multiple dates from January 2020 through April 2020. 2. The facility staff inaccurately documented that Novolog insulin was administered to Resident #8 on 4/1/20, 4/20/20 and 4/24/20. The findings include: 1. Resident #8 was admitted to the facility on 1/8/20 and discharged on 5/10/20. Resident #8's diagnoses included but were not limited to diabetes, high blood pressure and heart failure. Resident #8's quarterly minimum data set assessment with an assessment reference date of 4/16/20 coded the resident as being cognitively intact. Section G coded the resident as requiring one person physical assistance with bathing. Resident #8's comprehensive care plan dated 1/10/20 documented, "ADLs (Activities of Daily Living) - The resident has an ADL self-care performance deficit r/t (related to) impaired mobility...BATHING/SHOWERING: The resident requires supervision with occasional staff	F 842		

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F 842	Continued From page 16 assistance with bathing/showering twice a week and as necessary." Review of CNA (Certified Nursing Assistant) bathing records revealed no bathing documentation for the following time periods: 1/11/20-1/23/20 1/25/20-2/6/20 2/27/20-3/11/20 3/13/20-3/19/20 4/1/20-4/13/20 4/15/20-4/30/20 Nurses' notes dated 3/6/20, 3/20/20 and 4/2/20 documented Resident #8 refused showers/bathing on those dates. Review of the clinical record also revealed that Resident #8 was discharged to the hospital on 4/27/20 and re-admitted on 4/30/20. On 10/20/20 at 3:43 p.m., a telephone interview was conducted with CNA #6, a CNA who cared for Resident #8. CNA #6 stated residents are provided showers/baths twice a week and CNAs are supposed to document provided showers/baths in the computer system. CNA #6 stated residents' scheduled shower days/shifts are entered into the computer system. CNA #6 stated sometimes residents will be provided showers on days/shifts other than what is programmed into the computer and when this occurs, the shower cannot be documented in the computer. CNA #6 stated that to the best of her knowledge, Resident #8 received showers/bathing twice a week. On 10/21/20 at 12:43 p.m., a telephone interview was conducted with CNA #7, a CNA who cared for Resident #8. CNA #7 stated residents are	F 842		

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F 842	Continued From page 17 provided showers/baths twice a week and CNAs are supposed to document provided showers/baths in the computer system. CNA #7 stated she did not recall Resident #8 missing a shower/bath except for when she refused. On 10/21/20 at 4:00 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the interim director of nursing were made aware of the above concern. The facility policy titled, "Charting and Documentation" documented, "2. The following information is to be documented in the resident medical record. c. Treatments or services performed..." No further information was presented prior to exit. 2. Review of Resident #8's clinical record revealed a physician's order dated 3/11/20 for Novolog insulin (used to treat diabetes) 100 units/milliliters- 4 units subcutaneously with meals. The order further documented to hold the insulin if the resident's blood sugar was less than 200. Review of Resident #8's April MAR (medication administration record) revealed documentation that the Novolog was administered on 4/1/20 at 12:00 p.m. when the resident's blood sugar was 158, administered on 4/20/20 at 8:00 a.m. when the resident's blood sugar was 128, and administered on 4/24/20 at 8:00 a.m. when the resident's blood sugar was 131, as evidenced by a check mark and nurses' initials. On 10/20/20 at 1:51 p.m., a telephone interview was conducted with LPN (licensed practical nurse) #9, the nurse who documented Novolog	F 842		

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F 842	Continued From page 18 was administered to Resident #8 on 4/1/20 at 12:00 p.m. and 4/20/20 at 8:00 a.m. LPN #9 stated Novolog should be held for a blood sugar less than 200 if that is what the physician's order documents to do and the nurse should sign off "other" on the MAR, indicating that the medication was held. LPN #9 was made aware that she documented Novolog was administered to Resident #8 on 4/1/20 when the resident's blood sugar was 158 and on 4/20/20 when the resident's blood sugar was 128. LPN #9 stated Resident #8's blood sugars fluctuated so much that she was very cautious with the resident's insulin. LPN #9 stated she may have clicked the button documenting that she gave Resident #8 Novolog on those dates but she did not administer the medication. On 10/20/20 at 2:09 p.m., a telephone interview was conducted with RN (registered nurse) #5, the nurse who documented Novolog was administered to Resident #8 on 4/24/20 at 8:00 a.m. RN #5 stated Novolog should be held for a blood sugar less than 200 if that is what the physician's order documents to do. RN #5 was made aware that she documented Novolog was administered to Resident #8 on 4/24/20 when the resident's blood sugar was 131. RN #5 stated if she did give the insulin when she should not have then she would have completed a medication error form. RN #5 stated it also could have been a documentation error. Note- the facility did not have any medication error forms on file for Resident #8 during April 2020. On 10/21/20 at 4:00 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2	F 842		

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F 842	Continued From page 19 (the interim director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 842		