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	495220	A. BUILDING _____ B. WING _____	C 12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 11/23/20 through 12/09/20. One complaint was investigated during the survey. Complaint number VA000050146 was substantiated with deficiencies. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of one closed resident record review (Resident #1) and one current resident review (Resident #2).	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 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).	F 656		1/5/21

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

Electronically Signed | 12/25/2020

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F 656	Continued From page 1 (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 clinical record review, staff interview, and during the course of a complaint investigation, the facility staff failed to develop a CCP (comprehensive care plan) in the area of diabetes for one of two residents in the survey sample, Resident #1. Findings include: Resident #1 was admitted to the facility on 07/29/20. Diagnoses for Resident #1 included, but were not limited to: CHF (congestive heart failure), DM (diabetes mellitus), high blood pressure, history of seizure disorder, chronic kidney disease, hypothyroidism, CAD (coronary artery disease), and hyponatremia.	F 656	No immediate action was taken due to resident no longer being in the center. A review of care plans for current residents with a diagnosis of diabetes was completed to ensure a comprehensive care plan was developed in the area of diabetes. The MDS Coordinator was educated by the Director of Nursing/designee on developing a comprehensive care plan in the area of diabetes when the resident has this diagnosis. The Director of Nursing/designee will during morning clinical meeting review	

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F 656	Continued From page 2 The most current full MDS was an admission assessment dated 08/04/20. This MDS assessed the resident with a cognitive score of 8, indicating the resident had moderate impairment in daily decision making skills. Resident #1's hospital discharge summary [prior to admission to the facility] dated 07/29/20 was reviewed. The discharge summary identified Resident #1 as diabetic and documented the resident had been receiving sliding scale insulin, as well as, receiving glucose checks four times daily during the resident's hospital stay from 07/23/20 through discharge 07/29/20. On 11/23/20 at approximately 1:40 PM, standing orders for Resident #1 were reviewed. The standing orders documented, "...ROUTINE STANDING ORDERS...Resident: [Name of Resident #1]...Room: [room number of Resident #1]...admit date: 07/29/20 [Resident #1's admission date]...Initiate orders as appropriate for the resident: ...Diabetic...LAB TESTS...fasting blood sugar [ACHS]...as ordered...Sliding Scale For Novo log SQ [subcutaneous] based on finger stick blood sugar...Give 0 units if BS [blood sugar] less than 200, Give 4 units if BS 200-250, Give 6 units if BS 251-300, Give 8 units if BS 301-350, Give 10 units if BS 351-400, Give 12 units if BS 401-450, Give 15 units if BS 451-500, Call physician if BS greater than 500...hypoglycemia...less than 50...notify MD...hyperglycemia...greater than 500 unless parameters have been set, notify MD..." Resident #1's initial care plan was reviewed and documented, "...regular diet RCS [reduced concentrated sweets]...Medications...Insulin...Blood glucose	F 656	new admissions for the diagnosis of diabetes and ensure a care plan has been developed. In addition, the Director of Nursing will review 4 care plans weekly to ensure major diagnosis are included in the comprehensive care plan. The results of the review will be discussed at the monthly QAPI. Once the committee determines the problem no longer exists the review will be conducted on a random basis. The CAO/DON are responsible for implementation of the plan of correction.	

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F 656	Continued From page 3	F 656		

checks: QID [four times daily]..."

Resident #1's medication list was reviewed and revealed that the resident was on two different oral diabetic medications, Glipizide 5 mg/milligrams daily and Januvia 100 mg daily, when admitted to the facility.

Resident #1's comprehensive care plan was then reviewed. There was no information regarding Resident #1 having diabetes, no information regarding the resident's oral diabetic agents, no information regarding hypo/hyperglycemia, and no information regarding any type of interventions for the care and maintenance of Resident #1's diabetes.

At 12:30 PM, the ADON (assistant director of nursing) and AOM (area operation manager) were made aware of the above information. The ADON stated, "there's nothing on there about diabetes?" The ADON was made aware that no information was found for Resident #1.

On 12/03/20 at 3:00 PM, RN (Registered Nurse) #1, who was also the MDS coordinator at that time was interviewed. RN #1 stated that when a resident is admitted, an initial care plan is done on paper by the admitting nurse. RN #1 stated that after the initial care plan is created, it is then put in her box or the Social Worker's box on the day of admission, and that information is referenced for the development of the comprehensive care plan. RN #1 was asked about Resident #1's initial care plan regarding diabetes and QID glucose checks. RN #1 stated, "If she [Resident #1] took insulin or took any kind of PO [by mouth] medication for diabetes, then it should have been on her CCP." RN #1 further

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F 656	Continued From page 4 stated that she isn't perfect and does miss things. No further information and/or documentation was presented prior to the exit conference to evidence that the facility staff developed and implemented a CCP for Resident #1 in the area of diabetes care and management.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		1/5/21

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F 657	Continued From page 5 by: Based on clinical record review, staff interview, and during the course of a complaint investigation, the facility staff failed to review and revise a CCP (comprehensive care plan) in the area of pressure ulcers for one of two residents in the survey sample, Resident #1. Findings include: Resident #1 was admitted to the facility on 07/29/20. Diagnoses for Resident #1 included, but were not limited to: CHF (congestive heart failure), DM (diabetes mellitus), high blood pressure, history of seizure disorder, chronic kidney disease, hypothyroidism, CAD (coronary artery disease), and hyponatremia. The most current full MDS (minimum data set) was an admission assessment dated 08/04/20. This MDS assessed the resident with a cognitive score of 8, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive to total assistance from at least two staff members for all ADL's (activities of daily living), including transfers, toileting, and hygiene. The resident was totally dependent upon staff for bathing. The resident was coded as not ambulating at all during the look back period. Resident #1's clinical records were reviewed. A nursing admission assessment dated 07/29/20 and timed 2:19 PM, assessed the resident's skin, under the "skin" section as having a "scratch" on the upper-mid back [vertebrae]. There was no other assessment information related to this scratch. No other skin issues or concerns were	F 657	No immediate action was taken since the resident is no longer in the center. Care plans of current residents in the center with pressure ulcers were reviewed to ensure the pressure ulcers has been addressed on the comprehensive care plan. The MDS Coordinator was educated by the Director of Nursing/designee on revising and updating care plans to reflect the resident's current functional and psychological status including pressure ulcers. The Director of Nursing/designee will review 4 care plans weekly to ensure the comprehensive care plan reflects the functional and psychological status of the resident including pressure ulcers. The results of the review will be discussed at the monthly QAPI meeting. Once the committee determines the problem no longer exists, review will be completed on a random basis. CAO/DON is responsible for implementation of the plan of correction.	

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F 657	Continued From page 6	F 657		

identified on this assessment for the resident's back, buttocks, or heels.

A Skilled Care Daily Documentation assessment dated 08/16/20 and timed 10:21 AM, documented for Resident #1 in section G. that the resident's skin was "warm" and in the "other skin condition" section, it was documented, "open area to sacral crease" and 'bed' was marked for the pressure reducing device. The narrative section of this assessment documented, "...continues to be skilled, alert to self...extensive assist with ADLs, incontinent of BB [bowel/bladder]. Treatments to sacral crease as ordered..."

The resident's physician's orders were then reviewed. An order dated 08/12/20 [start date: 08/13/20] documented, "Cleanse with dermaklenz, pat dry, and apply hydrocolloid dressing to intergluteal cleft every other day."

A skin assessment dated 08/19/20 [one day before the resident was transferred to ER] [created on 09/02/20 - 13 days after the resident expired] documented that the resident had a stage II pressure ulcer on the gluteal fold [the crease separating the buttocks from the thigh] and measured 3 cm [centimeters] long by 3 cm wide by 0.4 cm deep. There was no additional assessment information regarding this wound to determine the location or other wound characteristics.

All of Resident #1's progress notes within the clinical record were reviewed from admission [07/29/20] through discharge [08/20/20].

A late entry nursing note created on 09/02/20 11:30 AM [13 days after the resident expired] with

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F 657	Continued From page 7	F 657		

an effective date of 08/12/20 11:29 AM documented, "...called to room to look at open area to intergluteal cleft [the groove between the buttocks/sacrum area] on resident. Wound bed was pink, no odor, minimal drainage...MD [medical doctor] notified of open area."

A late entry nursing note created on 09/02/20 1:59 PM [13 days after the resident expired] with an effective date of 08/12/20 1:58 PM documented, "new orders for hydrocolloid dressing to gluteal cleft. RP [responsible party] aware."

A late entry nursing note created on 08/24/20 5:23 PM [4 days after the resident expired] with an effective date of 08/21/20 5:19 PM [one day after resident expired at hospital] documented, "...Intergluteal fold...Stage II present with wound bed beefy red, granulation tissue present, maceration noted to wound edges, no odor or drainage noted...hydrocolloid continues, RP/MD...aware...slight change noted from last week...signature ADON."

The resident's CCP (comprehensive care plan) was reviewed from admission [07/29/20 through 08/20/20] through discharge.

The CCP documented, "...Risk for Pressure Ulcers related to incontinence, limitations in mobility or movement...incontinence care as promptly as possible to keep resident clean...pressure reducing mattress...RD [Registered Dietitian] consult as needed...risk assessment as needed...turn and reposition frequently as needed...skilled therapy referral as needed for positioning..."

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F 657	Continued From page 8	F 657		

On 12/03/20 at 3:00 PM, RN (Registered Nurse) #1, who was also the MDS coordinator at that time was interviewed. RN #1 was made aware that according to facility documentation, Resident #1 developed a pressure ulcer while a resident at the facility, but there was no CCP (comprehensive care plan) updates for any pressure ulcer areas for this resident. RN #1 stated that the CCP is usually updated on a quarterly basis with the MDS assessment. RN #1 stated that she did not recall Resident #1 having any pressure ulcers or skin problems and therefore, would not have made any updates to her care plan. RN #1 stated the way she would find out information regarding pressure ulcers for residents, would be in morning meetings they would have and discuss any skin issues or other issues happening with residents and either she, the ADON (assistant director of nursing), or the corporate nurse would update the care plan accordingly at that time for the concerns discussed and identified. RN #1 stated if Resident #1 had a pressure ulcer or skin condition it should have been on the CCP. RN #1 stated that the treatment information related to skin or pressure ulcers would also be listed on the resident's CCP as an update. RN #1 was made aware that Resident #1 had no updates on the CCP related to pressure ulcers or skin conditions. RN #1 again stated that she did not recall Resident #1 having any skin problems or concerns.

No further information and/or documetnation was presented prior to the exit conference to evidence that facility staff reviewed and revised Resident #1's CCP in the area of pressure ulcers.

This is a complaint deficiency.

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F 684 SS=E	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 clinical record review, staff interview, facility document review and during the course of a complaint investigation, the facility staff failed to provide care and treatment services for diabetes management, and failed to follow a physician's order upon admission for daily weights for CHF (congestive heart failure) management for one of two residents, Resident #1. (1) Resident #1 was identified as a diabetic upon admission, standing orders for diabetes was ordered, but were not initiated. (2) Resident #1 had an order for daily weights for the care of CHF from the hospital; the order was not carried over to the resident's admission orders. Findings include: (1) Resident #1 was admitted to the facility on 07/29/20. Diagnoses for Resident #1 included, but were not limited to: CHF (congestive heart failure), DM (diabetes mellitus), high blood pressure, history of seizure disorder, chronic kidney disease, hypothyroidism, CAD (coronary artery disease), and hyponatremia. The most current full MDS (minimum data set)	F 684	No immediate action taken due to the resident is no longer in the center. A review of new admissions for the last 30 days was conducted to ensure discharge orders from the hospital and any standing orders pertinent to the resident have been completed and implemented. Licensed nurses have been educated by the Director of Nursing/designee on implementing admissions orders from the discharge summary and any pertinent standing orders for new admissions, unless otherwise specified by the provider. The Director of Nursing/designee will review new admission charts in morning clinical meeting to ensure discharge orders and any pertinent standing orders have been implemented unless otherwise specified by the provider. In addition, the review will also ensure there is documentation in the medical record if the provider specifies there are certain orders	1/5/21

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F 684	Continued From page 10 was an admission assessment dated 08/04/20. This MDS assessed the resident with a cognitive score of 8, indicating the resident had moderate impairment in daily decision making skills. Resident #1's hospital discharge summary [prior to admission to the facility] dated 07/29/20 was reviewed. The discharge summary identified Resident #1 as diabetic and documented the resident had been receiving sliding scale insulin, as well as, receiving glucose checks four times daily during the resident's hospital stay from 07/23/20 through discharge 07/29/20. Resident #1's facility admission orders dated 07/29/20 were reviewed. No orders were found for blood glucose checks. The resident's initial [Baseline] admission care plan was reviewed and documented, "[Name of Resident #1]...admission date: 07/29/20...regular diet RCS [reduced concentrated sweets]...Medications...Insulin...Blood glucose checks: QID [four times daily]..." Resident #1's medication list was reviewed and revealed that the resident was on two different oral diabetic medications, Glipizide 5 mg/milligrams daily and Januvia 100 mg daily, when admitted to the facility. Resident #1's MARs (medication administration records) were reviewed for July and August 2020. There was no physician's order or any information for insulin and/or blood glucose checks found on the resident's MARs. The resident's comprehensive care plan was then reviewed. There was no information regarding Resident #1 having diabetes, no information	F 684	he/she does not want carried over to their admission to the center. The results of the review will be discussed at the monthly QAPI meeting. Once the committee determines the problem no longer exists, review will be completed on a random basis. CAO/DON is responsible for implementation of the plan of correction.	

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F 684	Continued From page 11	F 684		

regarding the resident's oral diabetic agents, no information regarding hypo/hyperglycemia, and no information regarding any type of interventions for the care and maintenance of Resident #1's diabetes.

At 12:30 PM on 11/23/20, the ADON (assistant director of nursing) and AOM (area operation manager) were made aware that Resident #1's initial care plan had documented for this resident to have glucose checks four times a day. The ADON stated that they did not have orders from the hospital for glucose checks. The ADON was asked to see all of the resident's admission orders, if the facility had standing orders, and did Resident #1 have any standing orders. The ADON stated that they do have standing orders and they are initiated upon admission for each resident. The ADON was asked for a copy of Resident #1's physician and standing orders. The ADON was then made aware that the resident's baseline care plan information regarding blood glucose checks had not been carried over to the comprehensive care plan, and that there was no information on the comprehensive care plan for diabetes at all. The ADON stated, "There's nothing on there about diabetes?" The ADON stated that she would look for that information. The ADON was made aware of concerns that the initial care plan documented for Resident #1 to have glucose checks four times a day that they were not done, and the information was not carried over to the comprehensive care plan.

On 11/23/20 at approximately 1:40 PM, the ADON presented the standing orders for Resident #1. The standing orders documented, "...ROUTINE STANDING ORDERS...Resident: [Name of

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Resident #1]...Room: [room number of Resident #1]...admit date: 07/29/20 [Resident #1's admission date]...Initiate orders as appropriate for the resident: ...Diabetic...LAB TESTS...fasting blood sugar [ACHS]...as ordered...Sliding Scale For Novo log SQ [subcutaneous] based on finger stick blood sugar...Give 0 units if BS [blood sugar] less than 200, Give 4 units if BS 200-250, Give 6 units if BS 251-300, Give 8 units if BS 301-350, Give 10 units if BS 351-400, Give 12 units if BS 401-450, Give 15 units if BS 451-500, Call physician if BS greater than 500...hypoglycemia...less than 50...notify MD...hyperglycemia...greater than 500 unless parameters have been set, notify MD..."

Further review of the resident's clinical record revealed an order for: "07/29/20...MAY USE STANDING ORDERS...Initiate orders as appropriate for the resident..."

On 12/02/20 at approximately 9:30 AM, the administrator and interim DON (director of nursing) were asked for policies and procedures related to care and maintenance for diabetic residents.

On 12/02/20 at 10:00 AM, LPN (Licensed Practical Nurse) #2 was interviewed. LPN #2 was asked about Resident #1's initial care plan that documented blood glucose checks four times a day. LPN #2 stated that initial care plans are done upon admission and will have care orders for the resident. LPN #2 stated that when a resident is admitted and they are a diabetic, and "admitted on any oral agent, the resident will have blood sugars checked QID [four times daily]." LPN #2 stated that they will do QID blood sugar checks for 7 days and if stable the physician will

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discontinue. LPN #2 then stated, "then we do a hemoglobin A1C." LPN #2 looked at Resident #1's initial care plan and stated, "Was she on insulin?" LPN #2 was made aware that Resident #1 was on two oral diabetic agents. Resident #1 did receive insulin at the hospital prior to admission and was on blood glucose checks QID at the hospital, as well. LPN #2 stated, "We don't put anything into play that was in effect at the hospital." LPN #2 was then asked where do blood glucose orders/treatments come from. LPN #2 stated, "It's on the standing orders." LPN #2 looked at the copy of Resident #1's Standing Orders and pointed to the diabetic section. LPN #2 stated, "We automatically do QID, that's the frequency that it's ordered." LPN #2 was asked where the orders were that indicate QID, on the physician's order set or on the standing orders. LPN #2 stated, "That's what we do for new admissions, it may or may not be on the orders...we use the standing orders and the frequency is QID for 7 days, if a resident is stable for 7 days [after the QID blood glucose checks] the order falls off, if the resident isn't stable for 7 days then the physician will look at them and put them back at a specified ordered frequency. LPN #2 stated that it may be once a day or twice a day. LPN #2 was asked to look for the order. LPN #2 looked at Resident #1's clinical record while being interviewed, and stated that she did not see the specific order, but that there were standing orders. LPN #2 stated, "Here I'll show you." LPN #2 picked a resident that she admitted a few weeks prior with diabetes, showed the standing orders and showed the glucose checks QID and showed the how the order should have been put in and how the order "dropped off." LPN #2 stated that she was the admitting nurse for Resident #1 and that they will share admissions

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and help each other out with putting in orders or whatever needs to be done to help out. LPN #2 stated that she started the initial care plan and she did write in the QID glucose checks, as that was what Resident #1 should have received. LPN #2 was made aware that the resident did not have any blood glucose checks at all during her stay at the facility [07/29/20 admission through 08/20/20 discharge], until labs were drawn on the very day she was transferred to the local hospital on [08/20/20]. LPN #2 stated, "I see that [no blood sugars were done]."

LPN #2 then stated, "I can't tell you why there are no blood sugars on her, she didn't come with an order from the hospital to continue them." LPN #2 was asked about her statements earlier in the interview regarding the standing orders that were entered for this resident to initiate orders [including blood glucose checks] as appropriate for the resident and that she [LPN #2] had stated that was "automatic" for blood glucose checks to be done QID for 7 days for any resident admitted on oral diabetic medications. LPN #2 stated, "When the orders get put in, someone is supposed to go back and check to make sure...we have 24 hours to complete the admission, put in meds...and then someone will go back to check..." LPN #2 was asked if blood glucose checks should have been completed/entered for Resident #1. LPN #2 stated, "In my opinion, yes ma'am they should have been put in." LPN #2 then stated, "I don't think anyone did anything negligent, I think it just got overlooked."

LPN #2 stated that on that day [08/20/20], the resident was "real sleepy" and was "a little crackle" [lung sounds], LPN #2 stated that

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Resident #1 did not eat any lunch that day and that is when the orders were obtained have the chest X-ray done. LPN #2 stated the labs were ordered later that day and were drawn at the facility before she left work that day and she hand delivered the labs to the local hospital for result processing at the end of her shift. According to clinical records the labs were collected at 5:50 PM on 08/20/20 and the results were called back to the facility at 7:50 PM on 08/20/20. The lab results revealed a blood glucose level of 917 HC [High Critical] [blood glucose range: 74-106 mg/dl milligrams/deciliter]...BUN [blood urea nitrogen] 131 HC [range: 7-18 mg/dl]...Creatinine 5.46 HC [range: 0.55-1.02 mg/dl]. The chest X-ray had been completed earlier documented as complete at 12:33 PM 08/20/20 and reported results back to facility at 6:45 PM on 08/20/20. The results of the chest X-ray showed a moderate right lower infiltrate. The resident was transferred emergently to the hospital at approximately 8:15 PM according the nursing notes on 08/20/20.

A policy was presented for Hyper/Hypoglycemia that documented, "Hyperglycemia Definition: Diabetic Coma (also known as hyperglycemia) is a condition that occurs in diabetic residents when they do not receive enough insulin to metabolize carbohydrates, when there is increased stress, or infection. The onset is gradual. Signs and Symptoms: Should you observe a diabetic resident, or should a diabetic resident complain of any of the following symptoms, report it to your staff/charge nurse IMMEDIATELY: ...Breathing difficulties...sweet or fruity breath...flushed skin...loss of appetite...nausea and/or vomiting...thirst and dry tongue...dry skin...increased urination...senses are dulled...complains of aches...loss of

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consciousness...should any of these conditions exist...blood sample should be obtained to determine the blood glucose level...elevations in blood glucose should be reported to the charge nurse and physician, if indicated. Administer insulin sliding scale coverage as ordered...for readings that exceed the maximum coverage, administer the maximum insulin...immediately notify physician...blood glucose levels should be repeated frequently, until they normalize...Hypoglycemia Definition: Insulin Shock (also known as hypoglycemia) is a condition that occurs in diabetic residents when they receive too much insulin, miss a meal, or when they have too much physical activity. The onset is sudden. Signs and Symptoms: Should you observe a diabetic resident, or should a diabetic resident complain of any of the following symptoms, report it to your staff/charge nurse IMMEDIATELY: ...sweating...weakness, dizziness or faintness...hunger...not able to wake up...appears in a coma, unconscious, or partially unconscious..."

On 12/03/20 at 12:25 PM, Resident #1's physician was interviewed. The physician stated that he was aware Resident #1 was a diabetic and that the NP (nurse practitioner) usually will see the resident first and take care of initial orders. The physician stated that the facility follows accucheck (blood glucose checks) orders and that those are typically from the standing orders. The physician was made aware of Resident #1's blood sugar level of 917 on the day of transfer and concerns regarding the facility not obtaining any blood glucose checks at all during her stay at the facility. The physician stated that it is very unusual for someone to have a blood sugar of over 900 and that he had actually seen

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Resident #1 on the 18th [2 days prior to transfer] and stated that the resident looked fine, appeared to answer questions appropriately, and didn't see anything that would indicate concerns at that time. The physician then stated, that "...had we done accuchecks initially...there is no question that if we had...obviously 20/20 definitely would have [been alerted to a change]...it was probably just missed..." The physician stated that he was shocked that Resident #1 died and that he did not see any indication that would happen two days after he saw the resident.

On 12/03/20 at 1:00 PM, the NP was interviewed. The NP stated that if a resident is not on insulin, an A1C will be done, and usually accuchecks are done. The NP stated that if a resident is diabetic the nurses will put accuchecks in so we will have something to work with. The NP stated, "They automatically put that [accuchecks] in, that's just a standard of practice." The NP stated, "I don't go in and manually put in blood sugars, they [nurses] do that...it's automatic." The NP stated, "It's a given that they automatically check them [blood sugars]." The NP stated in response to the resident's 917 blood sugar, "I bet she was septic...but I don't know that for sure..."

On 12/03/20 at 3:00 PM, RN (Registered Nurse) #1, who was also the MDS coordinator at that time, was interviewed. RN #1 stated that when a resident is admitted, an initial care plan is done on paper by the admitting nurse. RN #1 stated that after the initial care plan is created, it is then put in her box or the Social Worker's box on the day of admission, and that information is referenced for the development of the comprehensive care plan. RN #1 was asked about Resident #1's initial care plan regarding

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diabetes and QID glucose checks. RN #1 stated, "If she [Resident #1] took insulin or took any kind of PO [by mouth] medication for diabetes, then it should have been on her CCP." RN #1 further stated that she isn't perfect and does miss things. RN #1 stated at that time [Resident #1's admission], "back in the summer with COVID going on" that "staff were calling off, we were all over the place" and that she and the ADON were doing their jobs and also working the floor. RN #1 stated that diabetes has its own care plan heading and it all fits under that. RN #1 stated that if someone is a diabetic, they should have a diabetic care plan that includes treatments, and interventions.

On 12/08/20 at 9:00 AM, the physician was again interviewed. The physician was made aware that Resident #1's standing orders were found in the orders section and listed diabetic orders, but were not initiated by nursing staff for Resident #1, although they were ordered. The physician stated that his NP is very thorough and on top of things and he did not feel that the NP would have missed those orders. The physician again stated, that when he saw Resident #1 he had no reason to suspect any impending renal failure or major changes. The physician stated that when Resident #1 was seen by him for admission on 08/18/20, he had looked at the A1C [from admission] and blood sugars from the last few days at the hospital [prior to 07/29/20], Resident #1 was on two oral diabetic medications and he didn't see any problems when he saw her on the 18th.

No further information and/or documentation was presented prior to the exit conference on 12/09/20.

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This is a complaint deficiency.

(2) Resident #1 was admitted to the facility with a diagnoses of CHF. The resident's hospital discharge summary indicated that CHF was a contributing factor for admission. Resident #1 was receiving the following medications upon admission, lasix [diuretic] 40 mg (milligrams) daily, Spironolactone [potassium sparing diuretic] 25 mg daily and Mybetriq [prevents urgent, frequent, or uncontrolled urination] 25 mg daily.

A hospital discharge instruction form, dated 07/29/20 documented, "...skilled nursing home...Instructions/Notify physician: If symptoms continue or become worse; Weight gain of 3 pounds, in a day or 5 pounds in a week...Notify Physician...."

Resident #1's admission physician's orders were then reviewed. An order for, "..Weights per protocol [order date: 07/29/20]..." was found in the resident's orders.

The resident's comprehensive care plan was reviewed and documented, "...risk for cardiac complications related to...congestive heart failure...administer medications as ordered...labs as ordered...observe for s/s [signs/symptoms] of cardiac complications and notify MD as indicated...vital signs as needed..."

Resident #1's care conference documentation dated 08/12/20 documented, "...Unspecified Systolic heart failure..."

On 11/23/20 at approximately 1:00 PM, the ADON (assistant director of nursing) was interviewed

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regarding weights. The ADON was asked how often resident's were weighed upon admission. The ADON stated that resident's will be weighed on admission and then monthly if there are no specific orders for weights from the physician.

On 12/02/20 at 10:00 AM, LPN #2 was interviewed regarding weights. LPN #2 stated, "Weights are usually done on admission and the next day and then may do a third day, then after that it's monthly." LPN #2 was asked about weighing residents in the bed or lift scales. LPN #2 stated that they don't have beds that weigh or have lifts with scales. LPN #2 was asked about the above order, and LPN #2 stated that was discharge instructions, and was not an order.

The resident's weight records were then reviewed. The following weights were documented as entered manually.

07/29/20 16:04 156.0 mechanical lift entered by RN #3
07/30/20 16:04 156.0 mechanical lift entered by RN #3
08/05/20 15:16 156.0 mechanical lift entered by RN #3
08/12/20 11:02 154.0 mechanical lift entered by RN #3
08/19/20 11:03 156.0 mechanical lift entered by RN #3

On 12/03/20 at 1:00 PM, the NP (nurse practitioner) was interviewed regarding Resident #1. The NP was made aware of the discharge instructions from the hospital regarding the above order. The NP stated, "They didn't put that in as an order?" The NP stated, "That's an order." The NP was made aware that it was not put in as

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F 684	Continued From page 21 an order on admission and there was no information in the resident's comprehensive care plan regarding this. The NP was asked how would anyone know if a resident had a 3 pound weight gain in a day or a 5 pound weight gain in a week, if the resident wasn't being weight daily. The NP stated, "You wouldn't." The NP stated that was an order and should have been entered upon admission. The NP stated that nursing enters order for CHF patients for daily weights, just like a diabetic would get accuchecks. No further information and/or documentation was presented prior to the exit conference to evidence that facility staff followed an admission order for Resident #1 regarding CHF care and maintenance.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review, and in the course of a	F 686	No immediate action was taken since the resident is no longer in the center.	1/5/21

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complaint investigation, the facility staff failed to ensure care and treatment services for the prevention of multiple pressure ulcers for one of two residents in the survey sample, (Resident #1)y, resulting in harm. Resident #1 was admitted to the facility on 07/29/20 without any pressure related skin issues. On 08/20/20, the resident had a significant change of condition and was taken to a local hospital emergently for life saving measures. Upon arrival to the hospital emergency department, the resident was found with multiple pressure related areas, which included: one, stage 1 pressure ulcer on the right heel; one, stage III pressure ulcer to the sacrum; a large stage II-III on the right buttock; and two, stage II pressure ulcers on the resident's back.

Findings include:

Resident #1 was admitted to the facility on 07/29/20. Diagnoses for Resident #1 included, but were not limited to: CHF (congestive heart failure), DM (diabetes mellitus), HTN (high blood pressure), history of seizure disorder, chronic kidney disease, hypothyroidism, CAD (coronary artery disease), and hyponatremia.

The most current full MDS (minimum data set) was an admission assessment dated 08/04/20. This MDS assessed Resident #1 with a cognitive score of 8, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as requiring extensive to total assistance from at least two staff members for all ADL's (activities of daily living), including transfers, toileting, and hygiene. The resident was assessed as requiring extensive assistance from one staff person for eating. The resident was totally dependent upon staff for bathing. The

A thorough skin assessment was completed for current residents in the center to ensure any skin issues have been documented and orders written. In addition, A review of current residents in the center with pressure areas was reviewed to ensure the order for wound care included the correct location of the pressure area.

Licensed nurses have been educated by the Director of Nursing/designee on the completion of skin assessments and documentation of skin issues. Education also included using the correct verbiage to describe the location of any skin issues. In addition, MD orders must specify the correct location of the wound being treated. Any area found on admission must have documentation of treatment and resolution in the medical record.

The Director of Nursing /designee will complete a second skin assessment on new admissions within 24 hours to ensure any skin issues have been identified and appropriate orders written. In addition, current residents in the center will have a skin assessment completed weekly by Nursing Leadership for prompt identification of new skin issues with the appropriate documentation in the medical record and new orders written with the correct location documented.

The results from the second skin assessments completed within 24 hours of a new admission and the skin

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F 686	Continued From page 23 resident was coded as not ambulating at all during the look back period. This MDS assessed Resident #1 with no pressure related areas or any other skin related issues or concerns. The resident's clinical records were reviewed. A nursing admission assessment dated 07/29/20 and timed 2:19 PM, assessed Resident #1 in the skin section as having a "scratch" on the upper-mid back [vertebrae]. There were no other skin concerns identified for Resident #1. There was no other information found regarding the identified scratch. The NP (nurse practitioner) documented on 08/05/20, "...congestive heart failure...weakness...has difficulty weight bearing due to painful knees...Diabetes type 2...patient is awake...no acute distress...SKIN: Inspection: No rashes or ulcers...general weakness...patient needs skilled nursing facility care at this time secondary to...DM (diabetes mellitus)...weakness. As a consequence, the patient has incurred a significant decline in the ability to perform activities of daily living and functional mobility...requires 24 hour per day rehabilitation nursing to address...bowel and bladder...labs, skin integrity, nutrition..." All of the resident's "Skilled Care Daily Documentation" assessments were reviewed from from admission through 08/20/20, specifically 08/12/20 through 08/20/20. The skilled care daily assessment documentation forms include a check off section [Section G. Skin] that specifically asked, "...General Condition	F 686	assessments completed weekly by Nursing Leadership will be discussed at the monthly QAPI meeting. This monitoring will be ongoing and will continue until the QAPI committee determines the issue has been resolved. CAO/DON is responsible for implementation of the plan of correction	

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of Skin: 1. intact, dry, warm, clammy, cyanotic, pale, jaundiced...2. Alterations in skin integrity: surgical wound, pressure ulcer, stasis/vascular ulcer, skin tear, laceration/abrasion...3. Other skin condition: [free text area] ...4. Pressure reducing device bed, chair...skilled note [Section K.- the skilled note section was a place to enter a narrative note].

A Skilled Care Daily Documentation assessment dated 08/16/20 and timed 10:21 AM documented in section G. that Resident #1s skin was "warm" and in the "other skin condition" section, it was documented, "open area to sacral crease" and "bed" was checked for the pressure reducing device. The narrative section documented, "...continues to be skilled, alert to self...extensive assist with ADLs, incontinent of BB [bowel/bladder]. Treatments to sacral crease as ordered..."

No other Skilled Care Daily Documentation assessments identified any type of skin issues or concerns for Resident #1.

Resident #1's physician's orders were then reviewed. An order dated 08/12/20 [start date: 08/13/20] documented, "Cleanse with dermaklenz, pat dry, and apply hydrocolloid dressing to intergluteal cleft every other day."

Resident #1's TARs [treatment administration records] were reviewed for the month of August 2020. The TAR documented that the above treatment was checked off as completed for August 13th, 15th, 17th, and 19th.

[The resident was sent to the hospital on August 20th, 2020 where according to Resident #1's

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hospital records, the resident was found with multiple, pressure wounds; the resident expired a short time later.]

A skin assessment dated 08/06/20 [created on 08/08/20] documented that Resident #1 had no new skin issues and the resident's general skin condition was moist and dry.

A skin assessment dated 08/14/20 [created on 08/14/20] documented that Resident #1 had no new skin issues and the resident's general skin condition was warm and dry.

A skin assessment dated 08/19/20 [one day before the resident was transferred to ER] [created on 09/02/20 - 13 days after the resident expired] documented that the resident had a stage II pressure ulcer on the gluteal fold [the crease separating the buttocks from the thigh] and measured 3 cm [centimeters] long by 3 cm wide by 0.4 cm deep. There was no additional detailed assessment information regarding this wound to determine the location or wound characteristics.

There were no physician's treatment orders found for a gluteal fold wound as documented above.

On 11/23/20 at approximately 1:25 PM, the ADON and the Area Operation Manager were informed of allegations of the complaint regarding Resident #1's skin condition upon arrival to the hospital on 08/20/20. The ADON stated that the resident only had "some shearing" when she went out to hospital on 08/20/20. The ADON stated that they do not use any type of wound documentation forms and that resident skin assessments are usually for skin issues, but not wounds. The

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ADON stated that they will write a nursing note in the resident's clinical record for wounds and further stated that they just started putting in wound measurements. The ADON stated that she will use a notebook/tablet that she will keep wound measurements and that is for her use, and not part of the clinical records. The ADON was asked to present any and all information and documentation regarding Resident #1's skin and wound problems/issues/concerns.

The notebook/tablet that the ADON referenced above was not presented. No additional information or documentation regarding Resident #1's skin or wounds was presented.

All of Resident #1's progress notes within the clinical record were reviewed from admission [07/29/20] through discharge [08/20/20].

A late entry nursing note created on 09/02/20 11:30 AM [13 days after the resident expired] with an effective date of 08/12/20 11:29 AM documented, "...called to room to look at open area to intergluteal cleft [the groove between the buttocks/sacrum area] on resident. Wound bed was pink, no odor, minimal drainage...MD [medical doctor] notified of open area."

A late entry nursing note created on 09/02/20 1:59 PM [13 days after the resident expired] with an effective date of 08/12/20 1:58 PM documented, "new orders for hydrocolloid dressing to gluteal cleft. RP [responsible party] aware."

A late entry nursing note created on 08/24/20 5:23 PM [4 days after the resident expired] with an effective date of 08/21/20 5:19 PM [one day

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after resident expired] documented, "...Intergluteal fold...Stage II present with wound bed beefy red, granulation tissue present, maceration noted to wound edges, no odor or drainage noted...hydrocolloid continues, RP/MD...aware...slight change noted from last week...signature ADON." There was no specific documentation to evidence the progression of this wound based on the documentation presented.

The wound documentation for Resident #1 was found with discrepancies, as well multiple late entries. The skin assessment dated 08/19/20 [created on 09/02/20, 13 days after the resident expired] documented a wound on the gluteal fold, the area where the lower buttock meets the upper thigh [no indication of location, right or left] the only wound evidenced with measurements.

The resident's complete POS [Physician's order set] was reviewed for the resident's entire stay, 07/29/20 through 08/20/20.

Resident #1 had an order for, "...08/12/20...start date: 08//13/20...cleanse with dermaklenz, pat dry, and apply hydrocolloid dressing to intergluteal cleft every other day for wound..." No order was found for a wound to the gluteal fold, as described above dated 08/19/20.

There were no physician progress notes or assessment information regarding Resident #1's skin condition, or degree of severity.

A physician's progress note dated 08/18/20 documented, "...Skin/Breast: No rashes or skin breakdown...Skin: See nursing assessment for detailed skin exam."

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No physician or NP documentation was found regarding any pressure ulcers for Resident #1.

Hospital records for Resident #1 were obtained for the date of 08/20/20. The ER Patient Progress Notes from the hospital documented, "...unresponsive in cardiac arrest...Assessment: pt [patient] arrived from [name of LTC facility] unresponsive and in cardiac arrest...pt was then cleaned and found to have very large, foul smelling stage III on sacrum with two, stage II decub on back as well...signed by hospital RN."

The Emergency Room note documented, "Time of initial provider contact: upon arrival...CHIEF COMPLAINT: Active code...76 year old who presents tonight in active CODE STATUS. Nursing home staff toned [sic] for EMS [emergency medical services] due to high blood glucose and right sided pneumonia. EMS arrived at 2016 [8:16 PM] and witnessed patient becoming unresponsive. CPR [cardiopulmonary resuscitation] was started and the patient was brought to ER [emergency room]...EXTREMITIES: Stage I decubitus ulcer right heel; large stage II-III decubitus ulcer on right buttock; there are 2 stage II decubitus ulcers on the mid back...hyperglycemia (greater than 900 mg/dl)...situation was very dire... Time of death was called at 2251 [10:52 PM]...signed by physician."

The resident's CCP (comprehensive care plan) was reviewed from admission [07/29/20 through 08/20/20] through discharge.

The CCP documented, "...requires assistance with ADL's...functional limitations in ROM [range of motion] to the bilateral upper and lower

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extremities...hoyer lift only for transfers X 2 staff...provide assistance with feeding as needed...Provide extensive to total assistance with bed mobility and/or repositioning in the bed and chair as needed...requires two person assistance for bed mobility...resident is incontinent...related to impaired mobility...check and change frequently...provide extensive assistance with toileting...provide pericare as needed...apply barrier cream as needed...Risk for pressure ulcers related to incontinence, limitations in mobility or movement...will maintain skin integrity...incontinence care as promptly as possible to keep the resident clean...pressure reducing mattress...turn and reposition frequently..."

The resident's CCP did not evidence that the resident had any current skin issues or treatment interventions for pressure ulcers.

On 11/23/20 at 3:00 PM via phone, the ADON was made aware of concerns regarding Resident #1's multiple pressure ulcers, found upon arrival to the hospital on 8/20/20 and the lack of skin/wound assessment information, as well as extended delay in documenting late entries regarding wound information, along with discrepancies in documentation. The ADON stated that she had looked at Resident #1 two days prior to the resident leaving for the hospital [08/18/20] and stated that she couldn't imagine the pressure ulcer getting that bad that quick.

On 12/02/20 the administrator was asked for a policy on pressure ulcers. The policy documented, "...A weekly assessment should be done on all wounds requiring treatment. This should include measurement and a description.

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Preferably, this will be done on an assessment sheet and placed near the nurses notes on the chart so nurses will be aware of the progress...There must be a specific order for treatment...Documentation of the treatment should be done immediately after the treatment...the care plan should reflect the current status of the wound and appropriate goals..."

On 12/03/20 at 1:00 PM, the NP was interviewed via phone. The NP was made aware of the complaint allegations regarding Resident #1's skin. The NP stated that she did not recall Resident #1 having any type of wounds.

On 12/03/20 at 3:00 PM, RN #1 (also the MDS coordinator) was interviewed regarding Resident #1. RN #1 was made aware that Resident #1 did have a CCP (comprehensive care plan) for pressure ulcers, but there was no information in the CCP to evidence the resident actually had a pressure ulcer or any skin related concerns. RN #1 stated that the CCP would be updated on a quarterly basis or when an MDS assessment was completed. RN #1 stated that she did not recall Resident #1 having any pressure or skin problems. RN #1 stated that the way she would find out would be in morning meetings they would discuss any issues, and either she or the ADON would update the care plan accordingly. RN #1 further stated that a book/binder was kept in the ADON's office that had a sheet (Pressure Injury Management Record) for resident's with pressure ulcers. RN #1 stated these sheets were very detailed and had an area for acquired/not acquired, measurements, stage, treatment in place, color, etc. RN #1 stated that would only be filled out if the resident had a pressure ulcer.

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F 686	Continued From page 31 RN #1 stated that information should be kept in the resident's clinical record and would be uploaded into the computer. RN #1 stated that these were completed on a weekly basis. RN #1 was made aware that were none of these documents found in Resident #1's closed clinical records or in the EMR (electronic medical records). RN #1 again stated that she did not recall Resident #1 having any skin problems or concerns. No further information or documetnation was presented prior to the exit conference to evidence that facility staff provided Resident #1 with appropriate care and treatment services for the prevention and development of pressure ulcers, that resulted in actual harm for Resident #1. This is a complaint deficiency.	F 686		
F 777 SS=D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and in the course of a complaint investigation, the	F 777	No immediate action was taken since the resident is no longer in the center.	1/5/21

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F 777	Continued From page 32 facility staff failed to follow physician's orders for radiology services for one of two residents in the survey sample, Resident #1. Resident #1 had a physician's order to have an X-ray of the right shoulder on 08/10/20 and the facility staff obtained an X-ray of the resident's left shoulder. Findings include: Resident #1 was admitted to the facility on 07/29/20. Diagnoses for Resident #1 included, but were not limited to: CHF (congestive heart failure), DM (diabetes mellitus), HTN (high blood pressure), history of seizure disorder, chronic kidney disease, hypothyroidism, CAD (coronary artery disease), and hyponatremia. The most current full MDS(minimum data set) was an admission assessment dated 08/04/20. This MDS assessed the resident with a cognitive score of 8, indicating the resident had moderate impairment in daily decision making skills. Resident #1's clinical records were reviewed. The resident's physician's orders revealed an order for: "...X-ray of R [right] shoulder one time only for 1 day...[order date: 08/10/20]...[start date: 08/10/20]...[end date: 08/11/20]...signature of NP [nurse practitioner]" Resident #1's radiology reports were then reviewed and revealed an X-ray completed on 08/10/20. The X-ray documented, "...shoulder 2 view...Procedure: 73030-(LT) [LEFT] shoulder 2 view...IMPRESSION: Negative left shoulder exam..." A nursing note dated 08/10/20 and timed 8:30 PM documented, "...in building at this time to	F 777	A review of radiology services for the last 30 days for current residents in the center was reviewed to ensure the x-ray was completed as per the MD order. Licensed nurses was educated by the Director of Nursing/designee on the writing and transcribing of physician orders and ensuring physician orders are completed as written for radiology services. The Director of Nursing/designee will review 5x weekly in morning clinical meeting new orders for radiology and verifying the order was completed correctly. The results of the review will be discussed at the monthly QAPI meeting. Once the committee determines the problem no longer exists, review will be completed on a random basis. CAO/DON is responsible for implementation of the plan of correction	

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F 777	Continued From page 33 complete X-ray. resident informed X-ray tech that her right shoulder did not need xrayed and that it was her left shoulder. X-ray tech spoke with this nurse and resident spoke with nurse and stated, "I know which shoulder it is." X-ray completed of left shoulder." A nursing note dated 08/11/20 and timed 12:39 AM documented, "...X-ray results reviewed and are negative. Placed on rounds for MD." A nursing note dated 08/11/20 and timed 10:07 AM documented, "...resident seen by FNP [family nurse practitioner] for review of R [right] shoulder X-ray. no new orders at this time." On 11/23/20 at approximately 12:30 AM, the ADON [assistant director of nursing] was interviewed regarding the above information. The ADON stated that Resident #1 was alert and oriented and told the nurse it was the wrong shoulder. The ADON was made aware that Resident #1 scored an 8 [moderate impairment in daily decision making skills] on the admission MDS. The ADON stated that Resident #1 told the nurse it was the wrong shoulder, so they did an X-ray of the left shoulder. The ADON was made aware that the physician's order was for the right shoulder, not the left. The ADON was then asked, why the physician wasn't notified and a new order obtained to X-ray the left shoulder. The ADON did not comment. No further information and/or documentation was presented prior to the exit conference to evidence that facility staff obtained an X-ray as ordered by the physician, of the resident's right shoulder.	F 777		
F 842 SS=D	Resident Records - Identifiable Information	F 842		1/5/21

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F 842	Continued From page 34 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, 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	F 842		

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F 842	Continued From page 35 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 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 clinical record review, staff interview and during a complaint investigation, the facility staff failed to ensure a complete and accurate clinical record for one of two resident in the survey sample, Resident #1. Resident #1's clinical records documented throughout that the resident's code status was a full code, the resident also had a DDNR in the resident's chart. Findings include:	F 842	No immediate action was taken since the resident is no longer in the center. An audit was completed for current residents in the center to verify CODE status and to ensure the appropriate documents/physician orders/and care plan reflects the wishes of the residents/RP.	

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F 842	Continued From page 36 Resident #1 was admitted to the facility on 07/29/20. Diagnoses for Resident #1 included, but were not limited to: CHF (congestive heart failure), DM (diabetes mellitus), HTN (high blood pressure), history of seizure disorder, chronic kidney disease, hypothyroidism, CAD (coronary artery disease), and hyponatremia. The most current full MDS(minimum data set) was an admission assessment dated 08/04/20. This MDS assessed the resident with a cognitive score of 8, indicating the resident had moderate impairment in daily decision making skills. Resident #1's clinical records were reviewed. Resident #1's physician's orders were reviewed and included an order for, "...Full Code [active] [order date: 07/29/20..." Resident #1's initial care plan dated 07/29/20 documented, "...Code Status: FULL..." Resident #1's CCP (comprehensive care plan) was reviewed and did not document any information regarding code status. A care plan conference summary dated 08/12/20 documented, "...FULL CODE..." Resident #1's progress/nursing notes documented that the resident was a full code. A NP (nurse practitioner) note dated 08/05/20 documented, "...Code Status: Full Scope of Treatment..." During a review of Resident #1's clinical record on 11/24/20 a copy of a DDNR [durable do not	F 842	Licensed nurses/Social Services was educated by the Director of Nursing/designee on ensuring appropriate documents/physician orders and care plan reflects the wishes of the resident/RP in regard to the resident's CODE STATUS. The Director of Nursing/designee will review CODE STATUS of current residents in the center weekly to ensure appropriate documents/physician orders/ and care plan reflects the wishes of the resident/RP. The results of the review will be discussed at the monthly QAPI meeting. Once the committee determines the problem no longer exists, review will be completed on a random basis. CAO/DON is responsible for implementation of the plan of correction	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	C 12/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

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F 842	Continued From page 37	F 842		

resuscitate order] was found for Resident #1. The order was dated 07/29/20.

On 12/02/20 at approximately 12:30 PM, the interim DON (director of nursing) and the administrator were made aware of the above information. The administrator and DON were asked at that time about Resident #1's code status, as one can not be a full code and a DDNR at the same. The administrative staff stated that they would look into that.

The NP (nurse practitioner) was interviewed on 12/03/20 at 1:00 PM, regarding the above information and could not provide an explanation.

On 12/04/20 at 12:10 PM, Resident #1's daughter (responsible party) was interviewed via phone. She was asked about Resident #1's wishes for code status. The daughter stated that her mother wanted to receive CPR (cardiopulmonary resuscitation), but did not want to be kept alive on machines if she wasn ' t going to be normal.

On 12/04/20 at 1:38 PM, the administrator was interviewed regarding the above information. The administrator stated that the resident was a full code while in their building and it was documented on the care plan conference sheet, with the resident's signature. No explanation was provided as to why Resident #1 had an active DDNR order and an active full code order simultaneously.

No further information and/or documentation was presented prior to the exit conference to evidence that the facility maintained a complete and accurate clinical record for Resident #1 regarding code status.

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