State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0216	A. BUILDING: _____ B. WING _____	C 03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON HEALTH & REHAB CENTER, LLC	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(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) COMPLETE DATE
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility staff failed to comply with 12 VAC 5-371-300 A. Pharmacy Services Cross reference F tag 755 12VAC5-371-150 (A, B.1 &2). Resident Rights. Reference F557 12VAC5-371-220 (C1.). Nursing Services. Reference F686 12 VAC 5-371-150 (B.1). Resident Rights. Cross-Reference to F-550 and F-557. 12 VAC 5-371-220 (A, B). Nursing Services. Cross-Reference to F-686 12 VAC 5-371-300(B C). Pharmaceutical Services. Cross-Reference to F-431. 12 VAC 5-371-370 (A). Maintenance and Housekeeping. Cross-Reference to F-584 Based on facility documentation and staff interviews the facility staff failed to ensure at least one person was registered to receive automatic notifications from the Sex Offender Registry. The findings included: During a phone interview on 3/16/21 at approximately 1:15 P.M. the facility Administrator was asked who in the facility was registered to receive automatic notifications from the Sex Offender Registry. The Administrator stated, "I'm not sure but let me ask."	F 001	**F001** **4/15/21** **Corrective Action(s):** Administrator, Human Resources, and Admissions have registered for the sex offender notification on 3/16/2021. **Identification of Deficient Practices & Corrective Action(s):** The Human Resources Director and/or designee will conduct an audit. 100% of employees will be rechecked to ensure they are not currently a registered sex offender. Any/all negative findings will be corrected at the time of discovery. A Facility Incident & Accident form will be completed for any/all negative findings. **Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. Human Resources, Admissions and Administrator will be in-serviced by the RVPO on the requirements of registering for the Sex Offender Registry notification system. The Administrator, Human Resources and Admissions will begin to for residents and staff should they later become a sex offender.	

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

Lauren N Dawson LNHA — 4-9-2021

State of Virginia

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F 001	Continued From page 1 During a phone interview on 3/17/21 at approximately 9:45 A.M. with the Administrator and the Regional Vice President of Operations the Sex Offender Registry and facility automatic updates were discussed. The Administrator stated, "The previous Administrator left on March 2, 2021 and I started on March 3rd. I registered for the Sex Offender Registry yesterday. There was no one else in the facility that was registered to receive updates. It is very important to be registered in case someone moves in the neighborhood who is on the offender list, we want to keep our residents safe. Also if current staff members do something we would know as well The Administrator was asked if there was a facility policy to ensure at least one person was registered to receive automatic notifications from the Sex Offender Registry. The Administrator stated, "There is no facility policy." The Regional Vice President of Operations stated, "To ensure we always have someone registered I have sent a email to have the facility Administrators, Human Resources and the Admission Director all registered, so if there is turnover someone is registered." During a pre-exit on 3/18/21 at 10:40 A.M. the above information was shared. No further information was provided prior to exit. 12VAC5-371-140. D2. Policies and Procedures cross references to F622, F623, F625. 12VAC5-371-210.A3. Nurse Staffing cross references to F657. 12VAC5-371-220B. Nursing Services cross references to F684.	F 001	4-15-21 **Monitoring:** The Humans Resources manager is responsible for maintaining compliance. The Human Resources Manager and/or designee will save each notification email that is received, ensure it is not a current employee, print it out, and place it in a binder. The Administrator will conduct monthly audits of these records to maintain compliance. The Administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 4/15/2021**	

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F 001	Continued From page 2 12 VAC 5-371-170 (A). Please cross ref. to F-868 QA/QAPI 12 VAC 5-371-300 (L). Please cross ref. to F-761 Label/Store Drugs and Biologicals 12 VAC5-371-250 (G). Resident Assessment and Care Planning cross reference to F656 12 VAC5-371-220 (A) and (B) and (D). Nursing Services coss reference to F684 12 VAC5-371-220 (C) (1). Nursing Services cross reference to F686 12 VAC5-371-360 (A) and (B) and (E). Clinical Records cross reference to F842	F 001		

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite 3/16/21 through 3/18/21. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. The census in this 86 certified bed facility was 48 at the time of the survey. The survey sample consisted of 31 active and 5 closed records.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/16/21 through 3/18/21. Three complaints were investigated during the course of survey: VA00049153 Substantiated with unrelated deficiencies; VA00049453 Unsubstantiated and VA00048911 Substantiated with significant deficiency. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 86 certified bed facility was 48 at the time of the survey. The survey sample consisted of 31 active and 5 closed records.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		

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VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer R. Overbaugh
TITLE: LNHA Administrator
(X6) DATE: 4-9-2021

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 550	Continued From page 1 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and staff interviews the facility's staff failed to afford the opportunity to get out of bed daily as desired for 1 of 36 residents (Resident #50), in the survey sample. The findings included:	F 550	**F550** **Corrective Action(s):** Resident # 50 was interviewed for preference for getting out of bed. Residents care plan was revised to reflect preference. **Identification of Deficient Practices & Corrective Action(s):** Current residents have the potential to be affected by this deficient practice. **Systemic Changes:** Clinical nursing staff educated by DON/designee on resident rights to include being able to get up as desired. Newly hired clinical nursing staff will be educated. **Monitoring:** Social services/designee will interview 5 interviewable (BIMS of 12 or greater) residents weekly for 12 weeks for any concerns regarding resident rights to include being able to get out of bed as desired. Unit Manager/designee will observe 5 residents (non-interviewable) weekly for 12 weeks to ensure residents are out of bed as appropriate. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. **Completion Date: 4/15/2021**	4-16-21

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F 550	Continued From page 2 Resident #50 was originally admitted to the facility 12/3/14 and readmitted 2/22/21 after an acute care hospital stay. The current diagnoses included; Multiple sclerosis, diabetes and depression. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/27/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, total care of one person with bed mobility, personal hygiene, bathing, transfers, dressing, and toileting, and supervision after set-up with eating. An interview was conducted with Resident #50 on 3/16/21 at approximately 12:40 p.m. Resident #50 stated the walls were closing in on him because he had been under observation for 14 days after discharge from the hospital and since his transfer to the general population unit there continued to be days in which staff wouldn't get him up. Resident #50 stated he "required two people to get him out of bed using a mechanical lift and the staff states they don't have enough staff to get him up but his roommate requires the exact same assistance yet he is out of bed daily and early". On 3/17/21 at approximately 11: 00 a.m., and again at approximately 1:00 p.m., the resident was in bed due to a scheduled appointment which required him to be in bed until it was	F 550		

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F 550	Continued From page 3 completed. After staff learned the appointment was canceled at approximately 1:30 p.m., the resident wasn't transferred to get out of bed until late afternoon. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 3/18/21 at approximately 12:55 p.m. CNA #1 stated the facility had eliminated itself of problematic CNAs and hired others but; they continued to struggle with CNA staffing because of frequent call outs, especially Thursday through Sunday. CNA #1 further stated Resident #50 was left in bed on days in which staffing was a problem. On 3/18/21 the Resident #50 was again left in bed though, he constantly rung his call bell for someone to get him out bed. At approximately 2:20 p.m., Certified Nursing Assistant (CNA) #3 informed Resident #50, they were very busy and if there was time after rounds were completed for a specific assignment they would get him out of bed into his wheel chair but the plan was contingent on the length of time necessary to complete the other assignment. On 3/18/21 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated the resident should be out of bed as desired based on his preference and every effort would be made to accommodate the resident going forward.	F 550		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F 557		

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F 557	Continued From page 4 and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interview and review of facility documentation, the facility staff failed to ensure dignity was maintained for 3 residents (#409, #50, and #35). The facility staff failed to protect Resident #409 from body exposure to public view and provide his personal clothing. Resident #50 and #35 were not provided dignity covers for bedside drainage bags. The findings included: 1. Resident #409 was originally admitted to the nursing facility on 1/30/21 with diagnoses that included congestive heart failure, encephalopathy, cervical disc degeneration, and readmitted on 2/11/21 with an added diagnoses of TIAs (mini strokes), acute cystitis and kidney failure. The Admission Minimum Data Set (MDS) assessment dated 2/5/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 3 out of a possible score of 15 which indicated the resident was severely impaired in the necessary cognitive skills for daily decision making. Resident #409 required extensive assistance from one staff for bed mobility, transfers, ambulation in and out of his room, personal hygiene and bathing. The resident was	F 557	**F557** **Corrective Actions(s):** Resident # 50 and resident # 35 catheter bags were covered for dignity on 3/18/21. #35 catheter bag was discontinued on 3/18/21. Resident # 409 was provided clothing to prevent body exposure on 3/17/2021. **Identification of Deficient Practices & Corrective Action(s):** All other residents with a Foley catheter may have been potentially affected. The DON, and or Unit Manager will conduct a 100% review of all residents with a Foley catheter to identify any further dignity issues. Residents identified will be corrected at time of discovery and a Facility Incident & Accident Form will be completed. All other residents could be at risk for body exposure due to lack of clothing. The DON, and or Unit Manager will conduct a 100% review of all residents to ensure they have an appropriate amount of clothing. Residents identified will be corrected at time of discovery and a Facility Incident and Accident form will be completed.	4-15-21

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F 557	Continued From page 5 totally dependent on one staff for dressing and toilet use. The resident was assessed not steady without staff assistance for moving from a seated to a standing position, walking, turning around and face the opposite direction while walking, moving on and off the toilet and surface to surface transfer. Resident #409 was coded continent of bowel and bladder. The resident was assessed to have fallen in the last month, last 2-6 months and since admission without fractures. The care plan dated 2/1/21 identified that Resident #409 had a self-care deficit. The goal set by the staff for the resident was that his needs would be met. Some of the approaches the staff would implement to accomplish this goal included assist with activities of daily living, dressing, grooming, toileting and oral care. The following observations were made of Resident #409: On 3/16/21 at 11:15 a.m., the resident was sitting in his wheelchair with overbed table across from the nurse's station dressed in a hospital gown and non-skid socks on both feet. The resident could make request for basic needs, but was unable to carry on connection of thoughts during a prolonged conversation. On 3/16/21 at 12:25 p.m., the resident remained dressed as previously observed and eating his lunchmeal. He stated his lunch was, "Pretty good." On 3/16/21 at 1:00 p.m., the resident was walking around in his room without a hospital gown in just his brief and non-skid socks.	F 557	**Systemic Changes:** The facility Policy and Procedure for Foley Catheter usage and Foley Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be in-serviced by the DON/designee on the policy and procedures for proper Foley Catheter care to include the covering of the catheter to maintain dignity. Nursing staff was educated on dignity, resident rights to include use of dignity cover for Foley catheter drainage bags and ensuring dressed appropriately by Don/designee. Newly hired nursing staff will be educated upon hire. Residents identified as having no or limited clothing will be identified and corrected at time of discovery. **Monitoring:** 5 residents with foley catheters will be audited weekly for 12 weeks to ensure foley bag is covered by Unit Manager/designee. 5 residents weekly for 12 weeks will be observed by administrator/designee for appropriate clothing. Social service manager/designee will interview/observe 5 residents weekly for 12 weeks for any potential clothing needs. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. **Completion Date: 4/15/2021**	4-15-21

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F 557	Continued From page 6 On 3/16/21 at 1:25 p.m., the resident continued to walk around in his room without clothing as previously observed. The resident was holding onto foot of the bed to the end table, reaching out to this surveyor. Two staff persons were summoned to the room by this surveyor to assist the resident. Certified Nursing Assistant (CNA) #3 and Licensed Practical Nurse (LPN) #6 came to the resident's room and when asked if he had clothing, they stated that the resident had no family and no clothing. LPN #6 said the resident wore hospital gowns because he had no clothing. There was no clothes in any of the resident's drawers or hanging in his wardrobe, but there was a package of thick gray socks on his bedside table. LPN #6 put the resident's hospital gown back on and sat him in his wheelchair. CNA #3 said that the resident should have been at the nurse's station because he would try to stand up and possibly fall. The resident kept pointing to a package of thick gray socks and said "They would feel good." The LPN stated to the resident that he needed to wear the non-skid socks so he would not slip on the floor. When asked where his clothes were, he stated he did not know. On 3/16/21 at 2:30 p.m., Resident #409 was sitting in his wheelchair at the nurse's station on Unit I fully clothed with shirt, pants and regular thick gray socks. The resident stated he was "warmer today." The overbed table was in front of the resident and he was thumbing through magazines. LPN #6 stated the staff obtained the clothes from the lost and found. On 3/17/21 at 9:30 a.m., Resident #409 was fully clothed and also had on a zip up hoodie, sitting in his wheelchair at the nurse's station, finishing his breakfast meal. The Patient Care Assistant (PCA)	F 557		

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F 557	Continued From page 7 stated there was clothes in the lost and found for any resident without clothing and that several volunteer churches often donate clothing. On 3/18/21 at 11:47 a.m., an interview was conducted with the Unit Manager (UM) LPN #1 and the Social Worker (SW). They stated that the nursing staff did not approach either of them about the resident not having clothing. The UM stated she expected the staff to have let her know and she would have called the resident's legal guardian. She stated the resident came with a cane, but no clothes and wore hospital gowns, but the staff got clothing the last couple of days from the laundry lost and found. The SW said reiterated that if the lack of clothing was an issue she knew about she would have called the resident's legally appointed guardian to ask for clothing and shoes. On 3/18/21 at 1:34 p.m., An interview was conducted with the Admission's Coordinator who was asked if she knew whether or not the resident was admitted with personal belongings. She who stated she remembered seeing Resident #409 wearing clothing when he was on Unit II. The resident did not have a record of his personal belongings. On 3/18/21 at 4:14 p.m., a debriefing was held with the Administrator, Director of Nursing (DON) and Regional Vice President of Operations (RVPO). The DON stated she was going to research why the resident did not have any clothing. They voiced no one approached them about having to only put hospital gowns on the resident because he had no clothing. On 3/18/21 at 6:11 p.m., the DON and the	F 557		

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F 557	Continued From page 8 Admission's Coordinator said the resident had been transferred to the hospital from Unit II on 2/9/21 and returned on 2/11/21, spent time in quarantine and then transferred to Unit I on 2/25/21. The Admission's Coordinator said the CNA who packed up the resident's belongings was interviewed on the phone and stated she placed them in the soiled utility room on Unit II. They said, "We have now found his clothes in the soiled utility room. They were never transferred on 2/26/21 to his current room on Unit I. If a resident is gone 3 days, they are discharged and clothes are then placed in the soiled utility room based on the policy guidance for room changes during the Pandemic." There was no explanation as to why there was no attempt to locate the resident's clothing prior to 3/18/21 and or ensure clothing was obtained prior to 3/16/21 which resulted in his needless exposure to public view, and had the potential to negatively impact his dignity. The facility's policy and procedure titled "Resident Rights" undated indicated that all residents had the right to dignity, respect and freedom, and to be treated with consideration, respect, dignity and security of possessions.	F 557		

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	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 557	Continued From page 9 2. The facility's staff failed to maintain Resident #50's dignity by ensuring the bedside drainage bag fluid was concealed from view. Resident #50 was originally admitted to the facility 12/3/14 and readmitted 2/22/21 after an acute care hospital stay. The current diagnoses included; Multiple sclerosis and neurogenic bladder. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/27/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. In section "H" (Bladder and Bowel) the resident was coded as requiring use of an indwelling catheter. On 3/17/21 at approximately 11:00 a.m., and again at 1:00 p.m., Resident #50 was observed in bed. Viewable from the hallway was a bedside drainage bag with approximately 600 milliliters (ml) of light yellow urine inside. On 3/18/21 at approximately 12:20 p.m., Resident #50 was again observed in bed. Viewable from the hallway was a bedside drainage bag with approximately 900 milliliters (ml) of light yellow urine inside. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 3/18/21 at approximately 12:55 p.m. CNA #1 stated the resident had a dignity cover for his bedside drainage bag because she put it on three days ago when the resident was up in the wheel chair. CNA #1 located the dignity cover in a chair in	F 557		

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F 557	Continued From page 10 Resident #50's room, she put the cover on the bedside drainage bag and left the room. On 3/18/21 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated a bedside drainage bags should have a dignity covers on it. 3. The facility's staff failed to maintain Resident #35's dignity by ensuring the bedside drainage bag fluid was concealed from view. Resident #35 was originally admitted to the facility 2/16/21 and the resident hadn't been discharged since this admission. The current diagnoses included; urinary retention. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/22/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #35's cognitive abilities for daily decision making were intact. In section "H" (Bladder and Bowel) the resident was coded as requiring use of an indwelling catheter. On 3/16/21 at approximately 1:45 p.m., Resident #35 was observed in bed with a bedside drainage bag viewable upon entering the room. The drainage bag contained yellow urine. On 3/18/21 at approximately 11:05 a.m., Resident #35 was again observed in bed. Viewable from the hallway was a bedside drainage bag holding yellow urine.	F 557		

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F 557	Continued From page 11 On 3/18/21 at approximately 12:10 p.m., Resident #35 was observed in bed. Viewable from the hallway was a bedside drainage bag containing yellow urine. An interview was conducted with Certified Nursing Assistant (CNA) #1 on 3/18/21 at approximately 12:55 p.m. CNA #1 stated the resident had a dignity cover for his bedside drainage bag because she put it on. CNA #1 stated she would put the cover on Resident #35's bedside drainage bag. On 3/18/21 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated a bedside drainage bags should have a dignity covers on it. The facility's policy titled "Indwelling Urinary Catheter Care Procedure" with a revision date of 11/3/20, read under Procedure #11; Ensure drainage bag is covered with a privacy/dignity cover.	F 557		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those	F 582		

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F 582	Continued From page 12 services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of	F 582	**F 582** **Corrective Actions(s):** Resident #59 discharged from the facility 12/18/2020. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving Medicare Skilled Services may have been potentially affected. The Business Office Manager will review all current residents that have Medicare Skilled Benefits to ensure that the termination of benefits process has been explained, is on time and that written notification has been or will be sent to the resident and/or Responsible Party and that a signature from the beneficiary has been obtained to acknowledge that they have received the notice of their Medicare benefits will be terminating. **Systemic Changes:** The Business Office Manager and the Social Services Director have been in-serviced on the procedure for notifying Medicare recipients on the termination of skilled services. Business Office Manager in-serviced on 3/22/2021 on incident involving resident #59. **Monitoring:** 5 residents receiving Medicare skilled services will be audited weekly for 12 weeks to ensure timely delivery of Notice of Medicare Non-Coverage document, audit will be carried to QAPI committee monthly for 3 months for review and revision as needed. **Completion Date: 4/15/2021**	4-15-21

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F 582	Continued From page 13 these regulations. This REQUIREMENT is not met as evidenced by: Based on a medical record review, facility document review and staff interviews the facility The facility staff failed to ensure a Notice of Medicare Non-Coverage was given timely prior to the last covered skilled day of 12/17/20 for 1 of 36 residents in the survey sample, Resident #59. The findings included: Resident #59 is a 75 year old admitted to the facility on 11/27/20 with diagnoses to include but not limited to Diabetes Mellitus, End Stage Renal Disease and Hypertension. Resident #59's medical record indicated the resident was discharged home on 12/18/20 at 11:00 A.M. The most recent MDS (Minimum Data Set) for Resident #59 was a Discharge Assessment with a ARD (Assessment Reference Date) of 12/18/20. Resident #59's BIMS (Brief Interview for Mental Status) score was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Resident #59's Notice of Medicare Non-Coverage (NOMNC) document with Skilled Nursing Services ending on 12/17/20 was reviewed and is documented in part, as follows: Page 1: The Effective Date Coverage if Your Current PT(Physical Therapy), OT(Occupational Therapy), ST(Speech Therapy) Services Will End: 12/17/20. Page 2:	F 582		

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F 582	Continued From page 14 Please sign below to indicate you received and understood this notice. I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting QIO (Quality Improvement Organization). Signature of Resident #59 Date: 12/17/2020. Signature of Director of Social Services Date: 12/17/2020. A phone interview was conducted on 3/18/21 at 9:07 A.M. with the facility Social Worker regarding how far in advance should residents be provided a Notice of Medicare Non-Coverage. The Social Worker stated, "If a resident is discharging you need to give the medicare notice three to five days before the discharge date. This gives the resident or family time to appeal, because they need to do their appeal before the services end." A phone interview was conducted on 3/18/21 at approximately 10:15 A.M. with the Administrator, who was asked what were the expectations for issuing a Notice of Medicare Non-Coverage to residents. The Administrator stated, "The notice should be given at least 48 hours prior to discharge so they have a chance to appeal." The facility policy titled "Medicare Cut Letter Policy" last revised on 1/29/2021 was reviewed and is documented in part, as follows: Policy: The Facility will assure all residents receive timely and appropriate notification of	F 582		

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F 582	Continued From page 15 Medicare non-coverage for services in accordance with State and Federal guidelines. III. Delivery of Notice: All Notices are to be issued to the Resident/beneficiary or an authorized representative when the Resident is not capable of comprehending the Notice contents. Notice must be issues in accordance with the Triggering events and prior to the delivery of medical care which is presumed to be non-covered, a change or termination of services, but no later than 2 days prior to the change or termination. A pre-exit phone debriefing was conducted at 10:45 A.M. with the Administrator the the above information was reviewed. Prior to exit no further information was provided.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		

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F 584	Continued From page 16 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility's staff failed to maintain 1 of 36 residents (Resident #50), wheel chair in a clean and sanitary manner. The findings included: Resident #50 was originally admitted to the facility 12/3/14 and readmitted 2/22/21 after an acute care hospital stay. The current diagnoses included; Multiple sclerosis, diabetes and depression.	F 584		

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F 584	Continued From page 17 The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/27/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. On 3/17/21 at approximately 1:00 p.m., observation was made of Resident #50's wheel chair. A large amount of crumbs and other debris was observed on the side and beneath the seat cushion. An interview was conducted with Resident #50 on 3/17/21 at approximately 1:00 p.m. Resident #50 stated he wasn't aware of his wheel chair getting clean. He further stated no one comes to clean it. On 3/18/21 at approximately 11:00 a.m., again the debris was observed to the wheel chair therefore; an interview was conducted with Patient Care Assistant (PCA) #1. PCA #1 stated she would clean the debris from the resident's wheel chair. PCA #1 stated she was unaware of wheel chair cleaning schedules but she would find out. PCA #1 didn't return with the information. On 3/18/21 at approximately 7:00 p.m., the above findings were shared with the Administrator. The Administrator stated she would look further into the concern.	F 584	**F 584** **Corrective Action(s):** Resident # 50's wheelchair noted to be dirty and in disrepair has been cleaned on 3/18/2021. **Identification of Deficient Practices & Corrective Action(s):** Current residents in wheelchairs have the potential to be affected by this deficient practice. Wheelchairs have been assessed, cleaned and repaired as needed. **Systemic Changes:** Nursing and therapy staff have been educated on reporting wheelchairs which are dirty and in need of repair to DON/Administrator/designee. New hires will be educated as part of orientation. A wheelchair cleaning schedule has been put in place. **Monitoring:** 5 wheelchairs will be audited weekly for 12 weeks by administrator/designee to ensure clean and in good repair. Results of audit will be taken to QAPI committee monthly for 3 months to review for revision as needed. **Completion Date: 4/15/2021**	4-15-21
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge-	F 622		

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F 622	Continued From page 18 §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger	F 622	**F622** **Corrective Actions(s):** Unable to correct Resident #15. **Identification of Deficient Practices & Corrective Action(s):** Residents discharged from the facility have the potential to be affected by this deficient practice. Review of discharges for 30 days for any trends and patterns will be conducted by Don/Designee. **Systemic Changes:** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or designee will in-service facility licensed staff on the documentation required to be submitted to the receiving facility when a resident is being transferred or discharged to the hospital or other outside health care facility. New hires will be educated as part of orientation. **Monitoring:** Clinical records of discharged residents will be audited 5 times a week for 12 weeks by Don/designee for completion of discharge requirements. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. **Completion Date: 4/15/2021**	4-15-21

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F 622	Continued From page 19 that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals;	F 622		

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F 622	Continued From page 20 (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to provide evidence that care plan goals were sent with one of 36 residents (Resident #15) upon transfer to the hospital on 1/7/21. The findings included: Resident #15 was admitted to the facility on 7/1/15 and readmitted on 1/11/21 with diagnoses that included but were not limited to stroke, high blood pressure, unspecified protein calorie malnutrition, and atrial fibrillation. Resident #15's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 1/23/21. Resident #15 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #15's clinical record revealed that he was sent out to the hospital on 1/7/21 for a possible stroke. The following was documented in a nursing note dated 1/7/21: "Resident at approximately 3pm resident noted with change in condition. He had difficulty speaking any words. Rt (right) side flaccid, unable to grasp with Rt hand. Unable to pull foot back and no response when rubbed bottom of right foot. He has a very strong grip with left hand and moving his left leg	F 622		

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	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 622	Continued From page 21 without difficulty. Call was placed to (Name of Nurse Practitioner), NP (Nurse Practitioner) and new orders to send him out 911. Attempted to call his 2 daughters, message left to return call to facility. Call placed to ED (Emergency Department) to give report, no answer at ED. Resident is his own responsible party. EMT's (Emergency Medical Technician) were made aware and that he is a full code." Review of Resident #15's "Acute Care Transfer Document Checklist," also failed to show that Resident #15's care plan or care plan goals were sent with Resident #15 upon transfer to the hospital. Review of Resident #15's SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form dated 1/7/21 also failed to show that care plan goals were sent with Resident #15 at the time of transfer. Further review of Resident #15's clinical record revealed that he arrived back to the facility on 1/11/21 with a new diagnosis of stroke. On 3/18/21 at 10:05 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #15's nurse. When asked what documents were sent with a resident upon transfer to a hospital, LPN #2 stated that nurses with send the facesheet, medication list, the transfer summary, and the bed hold policy. When asked if the care plan or care plan goals were sent with each resident upon transfer, LPN #2 stated, "Care Plan goals, no, unless its part of the transfer summary." On 3/18/21 at 3:40 p.m. during a pre-exit	F 622		

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F 622	Continued From page 22 conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. A policy could not be provided regarding the above concerns. No further information was presented prior to exit.	F 622		4-15-21
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623	**F623** **Corrective Actions(s):** Unable to correct Resident #15 and #258. **Identification of Deficient Practices & Corrective Action(s):** Residents discharged from the facility have the potential to be affected by this deficient practice. Review of discharges for 30 days for any trends and patterns will be conducted by Don/Designee. **Systemic Changes:** Social Services director was educated on documents required to be submitted to the state ombudsman when resident is transferred/discharged by Administrator/designee. **Monitoring:** Audits of discharged residents will be done weekly for 12 weeks to ensure appropriate and timely ombudsman notification; audit to be done by Administrator/designee. Results of audits will be taken to QAPI committee monthly for 3 months for review and revisions as needed. **Completion Date: 4/15/2021**	

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F 623	Continued From page 23 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 24 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and complaint investigation, the facility staff failed to notify the Long Term Care Ombudsman of two residents (Resident #258 and #15) of transferring to the hospital in the survey sample of 36 residents. The findings included:	F 623		

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F 623	Continued From page 25 1. Resident #258 was admitted to the facility on 06/03/20. This resident was diagnosed as having Tardue Dyskinesia, hypertension, anxiety, depression, Bipolar, Schizoaffective disorder, hyperlipidemia, and anemia. the ombudsman was not notified of Resident #258 transfer to the hospital. This resident was assessed being stand to pivot x 1 assist, alert and oriented times 1 to self. Resident noted to wander in other patient rooms and exit seeking. A wander guard placed on left ankle. A Nursing note dated 06/03/20 at 5:38 P.M. indicated: "Resident noted cursing loudly, screaming, and speaking to self. Resident noted pulling pants down, while walking in hallway." A Nursing note dated 06/04/20 at 6:48 P.M. indicated: 'Police arrived, in contact with local Community Service Board (CSB). Resident continue to be confused, yelling, and having hallucinations (talking to people who are not there). Resident does not follow directions, sitting on the floor, and then laid on the floor. Staff has made her environment secure. Resident's representative advised of status." A Nursing note dated 06/04/20 at 07:04 P.M. indicated: "Resident laying on the floor, Emergency Transport arrived to transport to hospital. Physician advised of resident's status to transfer to hospital emergency department." During an interview on 03/17/21 at 4:50 P.M. with the social worker, she was asked if the Ombudsman was notified? The social worker	F 623		

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F 623	Continued From page 26 responded, "I did not notify the ombudsman." The facility staff failed to notify the ombudsman of Resident #258 transfer to the hospital. 2. Resident #15 was admitted to the facility on 7/1/15 and readmitted on 1/11/21 with diagnoses that included but were not limited to stroke, high blood pressure, unspecified protein calorie malnutrition, and atrial fibrillation. Resident #15's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 1/23/21. Resident #15 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #15's clinical record revealed that he was sent out to the hospital on 1/7/21 for a possible stroke. The following was documented in a nursing note dated 1/7/21: "Resident at approximately 3pm resident noted with change in condition. He had difficulty speaking any words. Rt (right) side flaccid, unable to grasp with Rt hand. Unable to pull foot back and no response when rubbed bottom of right foot. He has a very strong grip with left hand and moving his left leg without difficulty. Call was placed to (Name of Nurse Practitioner), NP (Nurse Practitioner) and new orders to send him out 911. Attempted to call his 2 daughters, message left to return call to facility. Call placed to ED (Emergency Department) to give report, no answer at ED. Resident is his own responsible party. EMT's (Emergency Medical Technician) were made aware and that he is a full code."	F 623		

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F 623	Continued From page 27 On 3/18/21 at 12:50 p.m., an interview was conducted with OSM (Other Staff Member) #3, social services. When asked the process for notifying the long term ombudsman regarding an acute care transfer, OSM #3 stated that she was only notifying the long term ombudsman for emergency transfers at the end of each month. When asked if she could present information that she notified the long term care ombudsman regarding Resident #15's transfer, OSM #2 stated that she just notified the long term care ombudsman regarding all January and February 2021 transfers on 3/17/21. OSM #3 stated that she was not aware that that was her responsibility; that the Director of Social Services was doing that; and that the facility no longer had a director. Review of an email dated 3/17/21 at 6:58 p.m., from the social worker to the ombudsman, revealed that the long term care ombudsman was not notified of Resident #15's transfer to the hospital until 3/17/21. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. Facility policy titled, "Discharge/Transfer Letter Policy," documents in part, the following: "Social Service or designee will assure the original discharge/transfer letter is given to resident or guardian/sponsor, if applicable. 1. Copies will be sent to the Department of Health, Ombudsman Office...For emergency transfers, one list can be	F 623		

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F 623	Continued From page 28 sent to Ombudsman at the end of month."	F 623		4-15-2021
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and complaint investigation, the facility staff failed to provide two residents (Resident #258 and #15) with bed hold policy notice upon transfer to the	F 625	**F625** **Corrective Actions(s):** Unable to correct Resident #258 and #625. **Identification of Deficient Practices & Corrective Action(s):** Residents discharged from the facility have the potential to be affected by this deficient practice. Review of discharges for 30 days for any trends and patterns will be conducted by Don/Designee. **Systemic Changes:** Licensed Nurses will be educated on transfer/discharge process to include providing the bed hold policy with transfer/discharge by DON/designee. All newly hired License Nurses will be educated as part of orientation. **Monitoring:** Clinical records of discharged residents will be audited 5 times a week for 12 weeks by Don/designee for completion of discharge requirements. Results of audits will be taken to QAPI committee monthly for 3 months for review and revision as needed. **Completion Date: 4/15/2021**	

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F 625	Continued From page 29 hospital in the survey sample of 36 residents. The findings included: 1. Resident #258 was admitted to the facility on 06/03/20. This resident was diagnosed as having Tardue Dyskinesia, hypertension, anxiety, depression, Bipolar, Schizoaffective disorder, hyperlipidemia, and anemia. Resident #258 was not provided with a bed hold policy notice upon transfer to the hospital. This resident was assessed being stand to pivot x 1 assist, alert and oriented times 1 to self. Resident noted to wander in other patient rooms and exit seeking. A wander guard placed on left ankle. A Nursing note dated 06/03/20 at 5:38 P.M. indicated: "Resident noted cursing loudly, screaming, and speaking to self. Resident noted pulling pants down, while walking in hallway." A Nursing note dated 06/04/20 at 6:48 P.M. indicated: 'Police arrived, in contact with local Community Service Board (CSB). Resident continue to be confused, yelling, and having hallucinations (talking to people who are not there). Resident does not follow directions, sitting on the floor, and then laid on the floor. Staff has made her environment secure. Resident's representative advised of status." A Nursing note dated 06/04/20 at 07:04 P.M. indicated: "Resident laying on the floor, Emergency Transport arrived to transport to hospital. Physician advised of resident's status to transfer to hospital emergency department."	F 625		

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F 625	Continued From page 30 During an interview on 03/17/21 at 4:45 P.M. with the social worker, she was asked if Resident #258 was provided with a bed hold policy notice? The social worker responded, "I did not provide Resident #258 with a bed hold notice policy." The facility staff failed to provide Resident #258 with a bed hold policy notice upon transfer to the hospital. 2. Resident #15 was admitted to the facility on 7/1/15 and readmitted on 1/11/21 with diagnoses that included but were not limited to stroke, high blood pressure, unspecified protein calorie malnutrition, and atrial fibrillation. Resident #15's most recent MDS (Minimum data set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 1/23/21. Resident #15 was coded as being moderately impaired in cognitive function scoring 12 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #15's clinical record revealed that he was sent out to the hospital on 1/7/21 for a possible stroke. The following was documented in a nursing note dated 1/7/21: "Resident at approximately 3pm resident noted with change in condition. He had difficulty speaking any words. Rt (right) side flaccid, unable to grasp with Rt hand. Unable to pull foot back and no response when rubbed bottom of right foot. He has a very strong grip with left hand and moving his left leg without difficulty. Call was placed to (Name of Nurse Practitioner), NP (Nurse Practitioner) and new orders to send him out 911. Attempted to call his 2 daughters, message left to return call to	F 625		

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F 625	Continued From page 31 facility. Call placed to ED (Emergency Department) to give report, no answer at ED. Resident is his own responsible party. EMT's (Emergency Medical Technician) were made aware and that he is a full code." There was no evidence in the nursing notes that the bed hold policy was sent with Resident #15 at the time of transfer. Review of Resident #15's "Acute Care Transfer Document Checklist," also failed to show that the bed hold policy was sent with Resident #15 upon transfer to the hospital. Review of Resident #15's SNF/NF (Skilled Nursing Facility/Nursing Facility) to Hospital Transfer Form dated 1/7/21 also failed to show that the bed hold policy was sent with Resident #15 at the time of transfer. On 3/18/21 at 10:05 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #15's nurse. When asked what documentation was sent with a resident upon transfer to the hospital, LPN #2 stated that the bed hold policy was sent with each resident at the time of an acute care transfer. When asked if it should be documented what specific documents were sent with each resident at the time of a transfer, LPN #2 stated that nursing usually documents "all of it." When asked how we would determine if a bed hold policy was sent with Resident #15 at the time of his transfer, if it is not documented in his clinical record, LPN #2 stated that she was not sure, that she would have to find out. On 3/18/21 at approximately 11:30 a.m., an	F 625		

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F 625	Continued From page 32 interview was conducted with Resident #15. Resident #15 stated that because he was post having a stroke, he was not "with it" enough to remember if facility staff had gone over a bed hold policy with him at the time of transfer. On 3/18/21 at 1:17 p.m., an interview was conducted with OSM (Other Staff Member) #4, Admissions. When asked if the bed hold policy was discussed with each resident upon admission into the facility, OSM #4 stated that she will go over the admission packet, but does not go over the bed hold policy. OSM #4 stated that nurses were responsible for going over the bed hold policy upon transfer to the hospital. OSM #4 also stated that a hospital liaison will also go over that information with the resident or family while in the hospital; and the liaison will contact her with that information. When asked if she keeps documentation for each resident between her and the hospital liaison, OSM #4 stated that she did not; that these conversations were usually verbal over the telephone. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. Facility policy titled, "Discharge/Transfer Letter Policy," documents in part, the following: "The resident or responsible party will receive a bed hold notice along with the discharge/transfer letter, when applicable."	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		

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	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 656	Continued From page 33 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). (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.	F 656	**F656** **Corrective Actions(s):** Resident #6's orders were reviewed, care plan reviewed and appropriate device in place. **Identification of Deficient Practices & Corrective Action(s):** Current residents with and at risk for heel wounds have the potential to be affected by this deficient practice. An audit of residents observing residents for heels being floated will be conducted by DON/Designee. **Systemic Changes:** The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The nursing staff will be in-serviced by the DON and/or designee on the facilities Pressure Ulcer Treatment and Prevention Policy and Procedure including elevating, floating heels. All newly hired nurses will be educated during orientation. **Monitoring:** 10 residents will be audited weekly for 4 weeks, 5 residents weekly for 8 weeks for elevation/floating heels by Unit Manager/designee. Results of audits will be brought to the QAPI committee monthly for 3 months for review and revisions as necessary. **Completion Date: 4/15/2021** RECEIVED APR 12 2021 VDH/OLC	4-15-21

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F 656	Continued From page 34 (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 observations, resident interview, staff interviews and clinical record review the facility staff failed to implement interventions, heel boots, in the comprehensive care plan for 1 of 36 Resident's in the survey sample, (Resident #6). The findings included: Resident #6 was originally admitted to the facility on 12/10/2020. The resident was discharged to the hospital on 02/23/2021 and readmitted to the facility on 02/26/2021. The resident was discharged to the hospital on 03/04/2021 and readmitted to the facility on 03/08/2021. Diagnosis included but were not limited to, Peripheral Vascular Disease and Moderate Protein-Calorie Malnutrition. Resident #6's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 12/16/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #6 as requiring total dependence of 2 for bed mobility, dressing, toilet use, personal hygiene and bathing and supervision with set up help only for eating. On 03/17/2021 review of Resident #6's Clinical Record revealed the following: Review of Saber Braden Scale Pressure Ulcer Risk Assessment revealed the following:	F 656		

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F 656	Continued From page 35 Effective Date: 12/17/2020 Braden Score: 13 Braden Category: Moderate Risk. Review of the Comprehensive Care Plan revealed the following: Focus; Heel Boots: Resident at Risk for impaired skin integrity impaired mobility. Goal: Skin will be free of breakdown. Interventions: Elevate heels off mattress per routine and/or as needed. Review of the Treatment Administration Record for the period of 03/01/2021 - 03/31/2021 revealed that Resident #6 has an order which reads as follows: Right heel - clean with Normal saline, apply betadine, bordered dry dressing and wrap with kerlix every night shift. Start Date - 03/17/2021. On 03/18/2021 at approximately 12:05 p.m., requested that Certified Nursing Assistant (CNA) #4 pull back the covers from Resident #6 feet. After CNA #4 pulled the covers back and a pillow was observed under Resident #6's calves and the residents feet were crossed and her left heel was lying on the mattress. Observed right heel was wrapped with kerlix. CNA #4 stated, "I had the pillow under her heels to float her heels." When asked how did the pillow get under Resident #6's calves, CNA #4 stated, "She can move it." CNA #4 repositioned the pillow under Resident #6 lower legs to float the residents heels. Observed left heel to still be touching the mattress. When asked if Resident #6 wore heel boots, CNA #4 stated, " I don't usually work over here. I worked with her yesterday and today." When asked if Resident #6 wore heel boots yesterday, CNA #4 stated, "No." CNA #4 stated, "I can get some heel boots and put them on her if you want." When asked how do you know what type care a	F 656		

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F 656	Continued From page 36 resident needs, requires, CNA #4 stated, "I get report and will ask what care to provide." The Administrator, Director of Nursing and Regional Vice President of Operations was informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. When asked what are your expectations of the staff, Director of Nursing stated, "Should have on the heel poseys if its in the care plan." The facility did not present any further information about the finding.	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.	F 657		

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F 657	Continued From page 37 (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 by: Based on observation, resident interview, staff interviews and clinical record review the facility staff failed to failed to revise the care plan with a change in code status for one of 36 residents; (Resident #14) AND failed to ensure that the intervention, compression glove, was included in the comprehensive care plan for one of 36 residents, (Resident #27). The findings included: 1. Resident #14 was admitted to the facility on 4/21/17 with diagnoses that included but were not limited to atrial fibrillation, muscle wasting and atrophy, diverticulosis of the intestine, and vascular dementia without behavioral disturbance. Resident #14's most recent MDS (Minimum Data Assessment) was a quarterly assessment with an ARD (assessment reference date) of 1/7/21. Resident #14 was coded as being severely impaired in the ability to make daily decision on the Staff Assessment for Mental Status exam. Review of Resident #14's March 2020 POS (Physician Order Summary) revealed the following current order: "Full Code." This order was initiated on 12/7/20. Review of Resident #14's facesheet documented "Full Code" as her code status. Review of Resident #14's care plan dated 2/18/21	F 657	**F657** **Corrective Actions(s):** Resident #14 had DNR status confirmed, care plan revised 3/17/2021 Resident #27 had order reviewed with MD, care plan revised 3/17/2021. **Identification of Deficient Practices & Corrective Action(s):** Current residents in facility have potential to be affected by deficient practice of inaccurate care plan for code status. Current residents clinical records audited to ensure code status is correct and care planned by socials services director/designee. Current residents with devices, ie compression glove, audited to ensure care plans are current and accurate by MDS director/designee. Care plans updated to reflect current status. **Systemic Changes:** IDP team, educated on review and revision of care plans by DON/designee, to include code status, device use. Nursing Staff educated on following care plans by DON/designee. **Monitoring:** Social Services director/designee will audit new admissions weekly for 12 weeks to ensure code status is correct and care planned appropriately. 5 residents with devices, ie compression glove will be audited weekly for 12 weeks by Unit Manager designee to ensure appropriate use of care plan. Results of audits will be taken to QAPI committee meeting monthly for 3 months for review and revisions as needed. **Completion Date: 4/15/2021**	4-15-21

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F 657	Continued From page 38 documented the following: "Resident has chosen DNR (Do Not Resuscitate)." On 3/18/21 at 9:20 a.m., an interview was conducted with RN (Registered Nurse) #1, the MDS nurse. When asked who was responsible for revising the care plan, RN #1 stated that the floor nurses were responsible for revising the care plan for changes in the resident's status; but that MDS would review and revise the care plan quarterly. This writer showed RN #1 Resident #14's care plan. RN #1 stated that Resident #14's care plan should reflect Full Code and not DNR. RN #1 stated that Resident #14's care plan was inaccurate. RN #1 stated that Resident #14 used to be a DNR prior to 12/7/2020 and that it was not reflected on the care plan. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the above concerns. Facility Policy titled, "Comprehensive Care Planning," documents in part, the following: "The MDS Coordinator is to review the 24 hour Report daily for significant changes or changes in resident's ADL (Activities of daily living) status. The Care Planning coordinator will add minor changes in resident's status to the existing Care Plans on daily basis." 2. Resident #27 was admitted to the facility on 02/10/2021. Diagnosis included but were not	F 657		

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F 657	Continued From page 39 limited to, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Type 2 Diabetes Mellitus. Resident #27's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 02/13/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #27 as requiring total dependence of one person with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing and supervision with setup help only for eating. On 03/16/2021 at approximately 1:25 p.m. review of Resident #27's Physician Orders revealed an order that reads as follows: Pt to wear compression glove on R hand, remove PRN (As Needed) for hygiene. Revision Date: 03/04/2021. On 03/16/2021 at 2:00 p.m., conducted an interview with Resident #27. When asked if she could move her left arm, Resident #27 lifted her left arm and stated, "Yes." When asked if she could move her right arm, Resident #27 stated, "I can't move it as well I had a stroke." Resident #27's right hand observed to be edematous. Resident does not have on a compression glove. When asked if she wore the compression glove on her right hand, Resident #27 stated, "I think I use to but not lately." On 03/17/2021 review of Resident #27's Clinical Record revealed the following: On 03/17/2021 Nurse Practitioner Progress Note was reviewed and revealed the following: Skin: sacral pressure ulcer, turgor normal, cap	F 657		

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F 657	Continued From page 40 (capillary) refill < (less than) 3 sec (seconds), no cyanosis, warm dry, edema present to R arm and hand. On 03/17/2021 Admission Nurse Progress Note was reviewed and revealed the following: Effective Date: 2/10/2021 Type: Admission Edema is present right arm and hand. On 03/17/2021 Saber Admission Readmission Evaluation was reviewed and revealed the following: Effective Date 02/10/2021 10. Cardiovascular A. Edema Present A1. Edema Describe: right arm and hand. On 03/18/2021 at approximately 1:30 p.m., received copy of Occupational Therapy Treatment Encounter Notes from Unit Manager. Review of Note signed on 3/8/2021 05:07: 55 PM revealed the following and is documented in part, as follows: Date of Service: 3/8/2021 Summary of Daily Skilled Services: "RUE (Right Upper Extremity) positioned elevated on pillows to decrease worsening edema in RUE. Unable to locate compression glove." Review of Note signed on 3/8/2021 05:07:56 PM revealed the following and is documented in part, as follows: Date of Service: 3/8/2021 Summary of Daily Skilled Services: 97530: Pt (Patient) re-issued R compression glove. donned with max (Maximum) A (Assist) to decrease edema in R (Right) hand. Retrograde massage completed to further reduce edema to increase R hand functional use in order to increase I with ADLs (Activities Daily Living). An interview was conducted with Registered Nurse (RN) #1, MDS Coordinator, when asked is the order for compression glove addressed in Resident #27's comprehensive care plan, RN #1	F 657		

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F 657	Continued From page 41 stated, "I was not made aware of the order, I will care plan it." When asked should it be care planned, RN #1 stated, "Yes, should be monitored and checked so it doesn't cut off circulation." The Administrator and Director of Nursing and Regional Vice President of Operations was informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. When asked should the compression glove be addressed in the comprehensive care plan, Director of Nursing stated, "Yes." When asked what is the purpose of the comprehensive care plan, Director of Nursing stated, "Help guide the care to be provided to the resident."	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that facility staff failed to accurately obtain, assess and monitor weights per physician's order and plan of care for one resident, Resident #40 AND failed to ensure that 2 of 36 residents in the survey sample, (Resident #6, and #27) treatments were implemented.	F 684		

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F 684	Continued From page 42 The findings included: 1. Resident #40 was admitted to the facility on 6/2/20 with diagnoses that included but were not limited to heart failure, peripheral vascular disease, and psychotic disorder. Resident #40's most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an ARD (Assessment Reference Date) of 2/18/21. Resident #40 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status Exam. Review of Resident #40's March 2020 POS (Physician Order Summary) revealed the following order: "Weigh Resident Daily Notify MD (Medical Doctor) of 3 lb (pound) weight gain in one day/5 lb in one week." Resident #40's care plan dated 12/30/2020 documented in part the following: "Increased risk for nutrition problems r/t (related to) CHF (Congestive Heart Failure)...daily weights." Review of Resident #40's weights in his clinical record revealed that on 3/4/21 Resident #40 weighed 165.5 pounds. The next day (3/5/21) Resident #40 was documented as weighing 266.6 pounds (101.1 pound weight gain). Resident #40 was also documented as weighing 266 pounds on 3/6/21, 266.6 on 3/7/21, 266.1 on 3/8/21, 266 on 3/9/21, 201.7 on 3/12/21 and back down to 166.4 on 3/14/21. No weights were recorded for 3/10/21, 3/11/21, and 3/13/21. Review of Resident #40's clinical record revealed no indication that a re-weigh had been conducted	F 684	**F684** **Corrective Actions(s):** Resident # 40's attending physician was notified of failure to obtain weights as ordered. Orders clarified; care plan reviewed and current. Resident #6's attending physician was notified of failure to have heel boot in place. Orders verified, care plan reviewed and is current with place of care. Resident #27 attending physician was notified of failure to apply compression glove per order. Orders clarified and care plan reviewed and current. **Identification of Deficient Practices & Corrective Action(s):** Current residents who have physician orders have licensed Nurses educated by DON/designee on following physician orders and following care plans to include ordered weights, application of devices and treatment. **Systemic Changes:** Licensed Nurses educated by DON/designee on following physician orders and following care plans to include weights, devices and treatment. **Monitoring:** 10 residents weekly for 12 weeks to be audited for following MD orders; and care plans implementation by Unit Manager/designee. Results of audits taken to QAPI monthly for 3 months for review and revision as needed. **Completion Date: 4/15/2021**	4-15-21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 684	Continued From page 43	F 684		

due to the higher recorded weights from 3/5/21 through 3/12/21. There was no evidence that staff were monitoring Resident #40's weights.

Review of the March 2021 MARS (Medication Administration Record) and TARS (Treatment Administration record) failed to evidence any additional weights obtained.

On 3/17/21 at 3:25 p.m., an interview was conducted with CNA #2, a CNA on Resident #40's unit. When asked who was responsible for obtaining daily weights on residents, CNA #2 stated that the nursing aides were responsible. When asked how she obtains weights on residents who are totally dependent on staff for ADLS (Activities of daily living), CNA #2 stated that she would use the mechanical lift scale. When asked what she would do if she noticed a major discrepancy in a resident's weight; CNA #2 stated that she would alert the nurse or DON (Director of Nursing). When asked if she and the other nursing aides had been educated lately on how to accurately obtain weights, CNA #2 stated that she hadn't.

On 3/18/21 at 9:30 a.m., an observation was conducted of CNA (Certified Nursing Assistant) #1 obtaining a daily weight on Resident #40 using a mechanical lift scale. There were no concerns related to obtaining his weight. Resident #40 weight was recorded as 164.6 (pounds).

On 3/18/21 at 10:21 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #2, Resident #40's nurse. When asked why Resident #40 was on daily weights; LPN #2 stated that Resident #40 was on daily weights for his diagnosis of CHF (Congestive Heart Failure).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 44 When asked if there were parameters to notify the physician, LPN #2 stated that usually if a resident had a weight gain of 5 pounds in one week, she would notify the physician. When asked what would happen if a resident had a 100 pound weight gain in one day, LPN #2 stated that she would ask the CNAs (Certified Nursing Assistants) to do a reweigh. When asked if CNAs were responsible for obtaining daily weights, LPN #2 stated that the nursing aides obtain the weight and nurse enters in the weight into the system. When asked if the nurses were responsible for monitoring daily weights, LPN #2 stated that they were. When asked what had happened with Resident #40's weights from 3/5/21 through 3/12/21 documenting a 100 pound weight gain; LPN #2 stated the discrepancy must have been a error in documentation. When asked how an error was made six times on the clinical record, LPN #2 was not sure. LPN #2 stated that a re-weigh was probably done in response to the inaccurate weights. When asked if re-weighs should be documented on the clinical record, LPN #2 stated that re-weighs should be documented in a nursing note but that she didn't think Resident #40's re-weights were recorded. When asked how a resident can be assessed and monitored for daily weight gain if inaccurate weights are recorded in the clinical record and three days (3/10/21, 3/11/21, and 3/13/21) of the daily weights were missing; LPN #2 stated that she would have to find out that information. On 3/18/21 at 3:40 p.m. during a pre-exit conference; ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Vice President of Operations, and ASM #4, the Regional Director of Clinical Services were made aware of the	F 684		

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	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 684	Continued From page 45 above concerns. Facility policy titled, "Weights Policy," documented in part, the following: "D) Reweights: 1. For Residents who weigh > (greater) than 100#, all weight changes showing a gain or loss of 5 pounds or more from the previous weight require a reweigh within 24 hours. E) All significant weight changes must be communicated to the resident if appropriate, the attending physician and responsible party. F) Weight Documentation: 1. All weights for each Resident (Including, new admission, readmission, monthly, and weekly) are to be recorded in one central weight record. Appropriate methods for recording weights are: Electronic Health Record. Vital signs and Weight Record." 2. The facility staff failed to ensure heel boots were implemented per the person centered care plan.: Resident #6 was originally admitted to the facility on 12/10/2020. The resident was discharged to the hospital on 02/23/2021 and readmitted to the facility on 02/26/2021. The resident was discharged to the hospital on 03/04/2021 and readmitted to the facility on 03/08/2021. Diagnosis included but were not limited to, Peripheral Vascular Disease and Moderate Protein-Calorie Malnutrition. Resident #6's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 12/16/2020 was coded with a	F 684		

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	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 684	Continued From page 46 BIMS (Brief Interview for Mental Status) score of 03 indicating severe cognitive impairment. In addition, the Minimum Data Set coded Resident #6 as requiring total dependence of 2 for bed mobility, dressing, toilet use, personal hygiene and bathing and supervision with set up help only for eating. On 03/17/2021 review of Resident #6's Clinical Record revealed the following: Review of Saber Braden Scale Pressure Ulcer Risk Assessment revealed the following: Effective Date: 12/17/2020 Braden Score: 13 Braden Category: Moderate Risk. Review of the Comprehensive Care Plan revealed the following: Focus; Heel Boots: Resident at Risk for impaired skin integrity impaired mobility. Goal: Skin will be free of breakdown. Interventions: Elevate heels off mattress per routine and/or as needed. Review of the Treatment Administration Record for the period of 03/01/2021 - 03/31/2021 revealed that Resident #6 has an order which reads as follows: Right heel - clean with Normal saline, apply betadine, bordered dry dressing and wrap with kerlix every night shift. Start Date - 03/17/2021. On 03/18/2021 at approximately 12:05 p.m., requested that Certified Nursing Assistant (CNA) #4 pull back the covers from Resident #6 feet. After CNA #4 pulled the covers back and a pillow was observed under Resident #6's calves and the residents feet were crossed and her left heel was lying on the mattress. Observed right heel was wrapped with kerlix. CNA #4 stated, "I had the	F 684		

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F 684	Continued From page 47 pillow under her heels to float her heels." When asked how did the pillow get under Resident #6's calves, CNA #4 stated, "She can move it." CNA #4 repositioned the pillow under Resident #6 lower legs to float the residents heels. Observed left heel to still be touching the mattress. When asked if Resident #6 wore heel boots, CNA #4 stated, " I don't usually work over here. I worked with her yesterday and today." When asked if Resident #6 wore heel boots yesterday, CNA #4 stated, "No." CNA #4 stated, "I can get some heel boots and put them on her if you want." When asked how do you know what type care a resident needs, requires, CNA #4 stated, "I get report and will ask what care to provide." The Administrator, Director of Nursing and Regional Vice President of Operations was informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. When asked what are your expectations of the staff, Director of Nursing stated, "Should have on the heel poseys if its in the care plan." The facility did not present any further information about the finding. 3. The facility staff failed to ensure that Resident #27 was wearing a compression glove to the right hand per physician's order. Resident #27 was admitted to the facility on 02/10/2021. Diagnosis included but were not limited to, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Type 2 Diabetes Mellitus. Resident #27's Admission Minimum Data Set (MDS an assessment protocol) with an	F 684		

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F 684	Continued From page 48 Assessment Reference Date of 02/13/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #27 as requiring total dependence of one person with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing and supervision with setup help only for eating. On 03/16/2021 at approximately 1:25 p.m. review of Resident #27's Physician Orders revealed an order that reads as follows: Pt to wear compression glove on R hand, remove PRN (As Needed) for hygiene. Revision Date: 03/04/2021. On 03/16/2021 at 2:00 p.m., conducted an interview with Resident #27. When asked if she could move her left arm, Resident #27 lifted her left arm and stated, "Yes." When asked if she could move her right arm, Resident #27 stated, "I can't move it as well I had a stroke." Resident #27's right hand observed to be edematous. Resident does not have on a compression glove. When asked if she wore the compression glove on her right hand, Resident #27 stated, "I think I use to but not lately." On 03/17/2021 review of Resident #27's Clinical Record revealed the following: On 03/17/2021 Nurse Practitioner Progress Note was reviewed and revealed the following: Skin: sacral pressure ulcer, turgor nml, cap (capillary) refill < (less than) 3 sec (seconds), no cyanosis, warm dry, edema present to R arm and hand. On 03/17/2021 Admission Nurse Progress Note was reviewed and revealed the following:	F 684		

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	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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HAMPTON HEALTH & REHAB CENTER, LLC	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

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F 684	Continued From page 49 Effective Date: 2/10/2021 Type: Admission Edema is present right arm and hand. On 03/17/2021 Saber Admission Readmission Evaluation was reviewed and revealed the following: Effective Date 02/10/2021 10. Cardiovascular A. Edema Present A1. Edema Describe: right arm and hand. In at Resident #27 bedside on 03/17/2021 at approximately 1:45 p.m., did not observe compression glove on right hand. On 03/18/2021 at approximately 9:40 a.m., in at Resident #27's bedside and did not observe compression glove on right hand. On 03/18/2021 at approximately 10:00 a.m., requested that the Unit Manager, accompany surveyor to Resident #27's bedside. Resident lying in bed with eyes open. Requested that Resident #27 show us her right hand. Observed edematous right hand. When Unit Manager was asked if Resident #27 should be wearing a compression glove on the right hand, Unit Manager stated, "I will have to check." After departing Resident #27's room the physician order for the compression glove was reviewed with the Unit Manager. The Unit Manager stated, "I can't remember, she may have refused to wear the glove. I will have to check." The Unit Manager was made aware that during the period of 03/16/2021 through 03/18/2021 the resident had not been observed wearing the glove. On 03/18/2021 at approximately 1:30 p.m., received copy of Occupational Therapy Treatment Encounter Notes from Unit Manager. Review of Note signed on 3/8/2021 05:07: 55 PM	F 684		

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F 684	Continued From page 50 revealed the following and is documented in part, as follows: Date of Service: 3/8/2021 Summary of Daily Skilled Services: "RUE (Right Upper Extremity) positioned elevated on pillows to decrease worsening edema in RUE. Unable to locate compression glove." Review of Note signed on 3/8/2021 05:07:56 PM revealed the following and is documented in part, as follows: Date of Service: 3/8/2021 Summary of Daily Skilled Services: 97530: Pt (Patient) re-issued R compression glove. donned with max (Maximum) A (Assist) to decrease edema in R (Right) hand. Retrograde massage completed to further reduce edema to increase R hand functional use in order to increase I with ADLs (Activities Daily Living). On 03/18/2021 at approximately 1:40 p.m., an interview was conducted with the Unit Manager, when asked if Resident #27 should be wearing a compression glove on the right hand, Unit Manager stated, "Yes." The Administrator, Director of Nursing and Regional Vice President of Operations was informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. When asked what are your expectations of the staff, Director of Nursing stated, "They should make sure to have the glove on as ordered." The facility did not present any further information about the finding.	F 684		
F 686 SS=D	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	F 686		

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F 686	Continued From page 51 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 a complaint investigation, observations, staff and resident interviews and facility documentation, the facility staff failed to provide care and services to prevent pressure ulcers prior to identification at an advanced stage for 2 of 36 residents (R#13 and #408) in the survey sample which constituted harm for both residents. Resident #13's sacral pressure ulcer was first identified on 3/18/21 by senior nursing management as unstageable, as well as Resident #408's sacral pressure ulcer first identified on 3/7/20 at a Stage III. The findings included: 1. Resident #13 was admitted 12/30/20 with diagnoses that included congestive heart failure and right lung cancer. The Admission Minimum Data Set (MDS) assessment was dated 1/5/21 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated the resident was intact with the cognitive skills for daily decision making. The resident was coded to require limited assistance	F 686	**F686** **Corrective Actions(s):** Resident #13's physician and RP were notified wound treatment ordered, care plan reviewed and revised appropriately. Resident #408 no longer resides in facility. **Identification of Deficient Practices & Corrective Action(s):** Current residents have the potential to be affected by this deficient practice. Facility performed skin checks on current residents done by DON/designee. Any concerns addressed. **Systemic Changes:** Current nursing staff educated on wound prevention to include, turning and positioning, use of pressure reducing/relieving devices, and skin observation by DON/designee. **Monitoring:** 24 residents weekly will be reviewed for any skin issues, appropriate treatments, care plan updated by DON/designee for 12 weeks. Results of audit will be taken to QAPI monthly for 3 months for review and revision as needed. **Completion Date: 4/15/2021** RECEIVED APR 12 2021 VDHOLC	4-15-21

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F 686	Continued From page 52 of one person for bed mobility, and extensive assistance from one staff for transfers, dressing, personal hygiene, toilet use and bathing. The resident was not assessed to have pressure ulcers. The resident was coded for Hospice upon admission. Resident #13 was coded continent of bowel and bladder. The care plan dated 12/30/20 and revised on 3/18/21 identified that the resident was at risk for the development of pressure ulcers. The goal set by the staff for the resident was that she would maintain intact skin. Some of the approaches the staff would implement to accomplish this goal included complete Braden Scale per protocol, skin assessments per protocol, use pressure releasing devices as indicated, turn and reposition as indicated and diet as indicated. The care plan dated 3/18/21 also identified actual skin breakdown, unstageable. The goal set by the staff for the resident was that she would have no further preventable skin breakdown thru next review. Some of the approaches the staff would implement to accomplish this goal were to add an air mattress, treatment initiated on 3/18/21 and notify medical doctor if treatment was ineffective. The Braden scale dated 1/13/21 scored the resident with a score of 17 that indicated Resident #13 was at risk for pressure ulcers, need to implement preventative interventions. The significant areas on the Braden Scale were in sensory perception, activity, mobility and friction and shear. Some of the preventative interventions that should address these specific areas and would include skin assessment and inspection every shift, regular turning schedule, enable as much activity as possible, protect heels, use pressure redistribution surfaces, nutrition consult	F 686		

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F 686	Continued From page 53 (supplements, monitor intake, small frequent meals) and advance to a higher level of risk if other major risk factors are present (information obtained on 3/19/21 from reference dated 2014 https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/pressure_ulcer_prevention/webinars/webinar5_pu_riskassesst-tools.pdf). Review of "The Bi-Weekly Skin Checks" dated 3/5/21, 3/8/21, 3/11/21, 3/14/21 and 3/17/21 indicated Resident #369 did not have any current or newly identified skin issues. The following observations were made of Resident #13: On 3/16/21 at approximately 12:30 p.m., the resident was in bed with lunch tray on overbed table. On 3/16/21 at approximately 3:00 p.m., the resident was again observed in bed lying on a regular pressure reducing mattress. During the interview with the resident she was asked if there was anything this surveyor could do for her, to which she responded, "I feel like something different is going on with my tailbone, maybe it is due to a fall I had, but I am not sure. I did fall out of bed straight on my rump. They put cream on where I hit on the floor, but over the last couple of weeks, the pain continues a couple hours later. Now, it is giving me a fit, but I will get some more cream tonight, but it is not going to last." The Treatment Administration Record (TAR) indicated that the cream the resident was referring to was *Lidocaine 4 percent (%) to right hip and sacrum three times a day, ordered by the physician on 3/2/21. The fall the resident experienced was on	F 686		

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F 686	Continued From page 54 2/10/21 with no identified injuries or fractures from assessment and X-rays. *Lidocaine 4% cream is a non-greasy cream specially formulated with soothing agents, indicated as a topical anesthetic for use on normal intact skin for local analgesia (Retrieved on 3/22/21 from reference dated 2019 https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a3216e25-82bb-4905-ac0b-b2ef4aa32ea0). On 3/17/21 at approximately 11:30 a.m., Resident #13 was again observed in bed. When asked how her bottom was she stated, "If you do anything for me today, please have someone check my bottom, it hurts worse and worse. This is what hurts me the most now. I am trying to stay off it as best as I can. I have told my nurse, but I need them to do something other than pain medication." The pain assessment documentation indicated that the resident scored her pain on 3/17/21 for the 7:00 a.m. to 7:00 p.m. shift at a 6 out of a possible score of 10 (moderately strong pain). This surveyor approached LPN #3 and relayed the resident's complaint about her bottom. The LPN stated she would do a full skin assessment before she finished her shift at 7:00 p.m. LPN#3 filled out a "Bi-Weekly Skin Check" signed off on 3/17/21 at 3:02 p.m. that there were no current or new skin issues. No further nurse's notes were written by LPN #3. On 3/18/21 at 1:10 p.m., Resident #13 was observed in bed. Certified Nursing Assistant (CNA) #3 and LPN #5, who was giving the resident medications, were at the bedside. When asked how the resident was feeling, she stated,	F 686		

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F 686	Continued From page 55 "Last night a nurse put a wonderful pad on my bottom and it felt glorious, but I think it needs to be changed because it is crumpling up and starting to hurt again." CNA#3 assisted the resident to turn on her left side and a large pink foam boarded dressing was on the resident's sacral area. The distal portion of the dressing was crumpled, which enabled the CNA to peel it back and spread her buttocks. An obvious open area was identified on the resident's sacrum. The CNA said she was assigned the resident, but did not remove the pink dressing. LPN #5 also looked and stated, "I have only been here 3 days. I don't know what that is. I am from the agency and I am not qualified to assess this." The LPN did not contact another nurse to assess the open area. The resident was wearing a brief and stated that sometimes she is incontinent of urine. The resident was not assessed or care planned for incontinence. On 3/18/21 at 1:40 p.m., the aforementioned concerns were shared with the Director of Nursing (DON). She stated that she nor the Unit Manager (UM) LPN #1 were made aware by any aide or nurse of the resident's complaints about her bottom or that there was an open area on the resident's sacrum, but all licensed nurses were able to assess and stage wounds. The DON said she was going to check with the agency to find out what their skills were related to assessing alteration in skin integrity to include pressure ulcers. It was shared with the DON that this surveyor told LPN #3 specifically about the resident's complaint on 3/17/21 and that the LPN stated she would complete a full skin assessment. The information was also shared with the DON that someone put a large pink foam dressing on the resident's sacrum as observed on	F 686		

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	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 686	Continued From page 56 3/18/21 at 1:10 p.m. During the above interview, the DON called LPN #3 and asked if she performed a full skin assessment on 3/17/21 to include the resident's bottom and sacral area. LPN #3 said, "I tilted her propped up some pillows at her back and gave her some pain medication, but I did not spread her buttocks to assess her sacral area." The LPN stated she was not the nurse that placed a pink foam dressing on the resident's sacrum. LPN #3 was the nurse that completed the Bi-Weekly Skin-Check dated 3/17/21 that indicated no current or new skin issues were identified. At no time did this surveyor give an opinion to the DON regarding the area identified, so that she could make her own assessment without any influence. On 3/18/21 at 15:01 p.m., the DON assessed the resident's skin to identify an *unstageable sacral pressure ulcer with 100% yellow (slough/soft dead tissue) wound bed that was not present upon admission, 0.4 centimeters (cm) length by (x) 0.3 cm width and 0.1 depth. with periwound appearance red. The DON documented that the resident's pain level was a 6 out of a possible score of 10. A physician's order was obtained for *Dakins wet to dry gauze followed by application of a foam dressing. The DON stated she would apply a smaller foam dressing that would conform to the resident's sacral area. The DON stated she found out from the 7:00 p.m. (3/17/21) to 7:00 a.m. (3/18/21) LPN #7 that said she did not see an open area on the resident's sacrum, and only applied a pink foam pad, without an order, for comfort because the resident stated her bottom was hurting. On 3/18/21 at 4:14 p.m., a debriefing was held	F 686		

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F 686	Continued From page 57	F 686		

with the Administrator, DON and Regional Vice President of Operations (RVPO). The UMLPN #1 stated that she expected the nurses to have informed her of Resident #369's consistent complaints of sacral pain that was different from her normal pain, but she was not made aware. The UMLPN#1 stated, "The purpose of the bi-weekly skin assessments is to identify any skin problems early that are quickly treatable." It was a consensus of the group that it was acceptable to first identify pressure ulcers at an advanced stage. The DON said all in house regular mattresses are pressure reducing, and she would be communicating with Hospice to obtain an air mattress for Resident #369. They stated they have standards of care meetings in the morning, but did not have one on 3/18/21, but staff could have passed on the resident's complaints and notified the Unit Manager or the DON. The DON and the Regional Administrator stated "It is obvious, we need to do some training."

On 3/18/21 at 5:15 p.m., Resident #13 was observed in bed and stated she was thankful that she finally knew what the problem was and treatment would heal the area.

On 3/18/21 at approximately 5:30 p.m., the DON stated she called the Hospice nurse to ask if when she came to see the resident, on 3/18/21 at 11:30 a.m., did she identify the pressure ulcer on the resident's sacrum. According to the DON, the Hospice nurse said she completed a full skin assessment and did not identify any pressure ulcer, but she was on her way back to nursing facility. The DON stated, "It is clear that it that a thorough skin assessments are not being performed by the nurses to include the Hospice nurse, especially along with the resident's

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F 686	Continued From page 58 complaint of pain in that area where the pressure ulcer was located. Because of the laxity of her skin, they needed to have spread her buttocks apart, not just turn her and take a look. You would not see anything otherwise. " On 3/18/21 at approximately 6:45 p.m., the RVPO presented an action plan with Root Cause Analysis for pressure ulcers that identified "Not repositioning every 2 hours, increase in agency usage and early identification." It incorporated education of clinical staff on the importance of turning and repositioning residents, educate clinical staff on pressure ulcer staging, including agency staff and to educate C.N.A. to inform nurses of any identified skin issues. The following information was retrieved on 3/22/21 from the 2020 National Pressure Injury Advisory Panel (NPIAP) www.npiap.com 1. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. Inspect the skin at least daily for early signs of pressure injury, especially nonblanchable erythema. Assess pressure points, such as the sacrum, coccyx, buttocks, heels, ischium, trochanters, elbows and beneath medical devices. Consider bedfast and chairfast individuals to be at risk for development of pressure injury. 2. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible. Refine the assessment by including these additional risk factors: Fragile skin. Existing pressure injury of any stage, including	F 686		

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F 686	Continued From page 59 those ulcers that have healed or are closed. Pain in areas of the body exposed to pressure Repeat the risk assessment at regular intervals and with any change in condition. 3. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface... Consider level of immobility, exposure to shear, skin moisture, perfusion, body size and weight of the individual when choosing a support surface. Continue to reposition an individual when placed on any support surface. Use a breathable incontinence pad when using microclimate management surfaces. 2. The facility's staff failed to identify Resident #408's sacral pressure ulcer until it advanced to a stage 3 deteriorating to unstageable by 3/12/20 and the facility staff failed to demonstrate it was unavoidable.	F 686		

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F 686	Continued From page 60 Resident #408 was originally admitted to the facility 2/6/20. The Resident's diagnoses included; deconditioning related to a right tibial plateau fracture, myelodysplastic syndromes and hypothyroidism. The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/3/20 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #408's cognitive abilities for daily decision making were moderately impaired. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, personal hygiene, bathing, dressing, and toileting, and supervision after set-up with eating. Resident #408 was no longer a resident of the facility therefore; a closed record review was conducted. Resident #408 had the following risk factors for skin breakdown; fragile skin, a low body weight with fair intake, decreased bed mobility related to a fractured right tibial plateau, and episodes of incontinence. Review of the resident's current care plan dated 2/19/20, addressed skin tears only not a potential for pressure ulcers or an actual pressure ulcer was present, with a goal date through 5/19/20. The problem read; (name of resident) has impaired skin integrity as evidenced by skin tears to the right forearm. The goal read; Resident will demonstrate improvement of skin integrity within 30 days 5/19/20. The interventions included;	F 686		

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F 686	Continued From page 61 encourage meal consumption and fluid intake, monitor nutritional parameters, assist resident to eat/drink an adequate amount of nutrition, monitor lab values, follow prescribed treatment regimen, protective measures when in chair or bed, observe skin condition daily for skin excoriation, apply protective undergarments/pads, avoid constricting clothes, use bed cradle, foam mattress to avoid skin breakdown, provide adequate hydration, provide adequate nutrition, vitamins, protein carbohydrates, avoid pressure on extremities with skin protectors, assess actual areas of breakdown and document on skin sheet, keep skin clean and dry, position resident for comfort and minimal pressure on bony prominences. Braden and Skin assessments were requested for Resident #408, but only skin assessments dated 3/9/20, 3/22/20 and 3/31/20 were provided after multiple request. The 3/9/20 Daily Skilled Nurse's Note skin assessment was coded for abnormal skin color, macerated bottom and turn and reposition. The 3/22/20 skin assessment was coded for having fair, pale and moist skin, skin lesions or open wounds, bruises and ecchymosis. A 3/31/20, Daily Skilled Nurse's Note skin assessment was coded for assessment pressure ulcers only. A nurses's note dated 3/7/20 at 6:40 p.m., revealed the resident required one person assistance with activities of daily living, and the resident uses a bedpan but experiences episodes of incontinence. The nurse's note also stated the resident was identified with a facility acquired stage 3 pressure ulcer measuring 3 centimeters x 2 centimeters. The wound care assessment dated 3/7/20 further described the sacral	F 686		

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F 686	Continued From page 62 pressure ulcer as having 70% granulation tissue and 30% soft adherent necrotic tissue. The 3/7/20 pressure ulcer assessment further revealed the sacral pressure was with moderate serosanguineous exudate with distinct and attached edges. The following order was obtained; clean the wound to the sacrum with normal saline, apply calcium alginate, cover with Allevyn. The sacral wound's etiology was determined to be pressure related and the pressure ulcer continued to deteriorate based on the wound care physician assessment dated 3/11/20. It measured 2.2 centimeters by 1.6 centimeters, and was unstageable as revealed by 70% thick adherent black necrotic tissue (eschar) and 30% thick adherent devitalized necrotic tissue. Surgical excision of the devitalized and necrotic subcutaneous tissue was performed. A new treatment order was ordered by the wound care physician, it read; clean the wound with normal saline, apply Santyl ointment, apply Dakins moist gauze and cover. The wound care physician's progress note also stated the resident verbalized pain of a 6 out of 10. The wound care physician offered further recommendations to off-load the wound, reposition the resident per facility protocol and use of a low air loss mattress. On 3/18/20 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultants. An opportunity was offered to the facility's staff to present additional information. It appears in the body of this writing. Assessment 1. Consider bedfast and chairfast individuals to	F 686		

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F 686	Continued From page 63 be at risk for development of pressure injury. 2. Use a structured risk assessment, such as the Braden Scale, to identify individuals at risk for pressure injury as soon as possible (but within 8 hours after admission). 3. Refine the assessment by including these additional risk factors; Fragile skin, Existing pressure injury of any stage, including those ulcers that have healed or are closed, Impairments in blood flow to the extremities from vascular disease, diabetes or tobacco use, Pain in areas of the body exposed to pressure. 4. Repeat the risk assessment at regular intervals and with any change in condition. Base the frequency of regular assessments on acuity levels: Acute care ... Every shift, Long term care ... Weekly for 4 weeks, then quarterly, Home care ... At every nurse visit (https://npiap.com/general/custom.asp?page=PreventionPoints) 5. Develop a plan of care based on the areas of risk, rather than on the total risk assessment score. For example, if the risk stems from immobility, address turning, repositioning, and the support surface. If the risk is from malnutrition, address those problems. Preventing pressure ulcers Pressure ulcers are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. When this happens, a pressure ulcer may form. You have a risk of developing a pressure ulcer if you:	F 686		

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F 686	Continued From page 64 · Spend most of your day in a bed or a chair with minimal movement · Are overweight or underweight · Are not able to control your bowels or bladder · Have decreased feeling in an area of your body · Spend a lot of time in one position You will need to take steps to prevent these problems; You, or your caregiver, need to check your body every day from head to toe. Pay special attention to the areas where pressure ulcers often form. These areas are the: · Heels and ankles, Knees, Hips, Spine, Tailbone area, Elbows, Shoulders and shoulder blades, Back of the head Ears. After urinating or having a bowel movement; Clean the area right away. Dry well., Ask your provider about creams to help protect your skin in this area. *Call your health care provider if you see early signs of pressure ulcers. These signs are: Skin redness, Warm areas, Spongy or hard skin, Breakdown of the top layers of skin or a sore. (https://medlineplus.gov/ency/patientinstructions/000147.htm) *Unstageable pressure ulcer/injury is a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage III or Stage IV pressure injury will be revealed (retrieved on 3/22/21 from document Prevention and Treatment of Pressure Ulcers/Injuries, third	F 686		

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F 686	Continued From page 65 edition, European Pressure Ulcer Advisory Panel, National Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance third edition, p. 42, 2019). *Dakins solution is a dilute sodium hydrochloride (NaClO) solution that is commonly known as bleach. The mixture of sodium peroxide (NaO) and hydrochloric acid (HCl) produces sodium hydrochloride. It has a solvent action on dead cells that hastens the separation of dead tissue from living tissue (retrieved on 3/22/21 from reference dated 2021 https://www.ncbi.nlm.nih.gov/books/NBK507916/) . COMPLAINT DEFICIENCY	F 686		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure that 1 of 36 residents (Resident #10) in the survey sample had an order for Dialysis. The findings included: Resident #10 was admitted to the facility on 12/14/2020. Resident #10 was discharged to the hospital on 02/25/2020 and readmitted to the	F 698		

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F 698	Continued From page 66 facility on 03/02/2021. Diagnosis included but were not limited to, HTN (Hypertension) and End Stage Renal Disease. Resident #10's Admission Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/18/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #10 as requiring supervision with setup help only with eating, limited assistance of 1 with bed mobility, dressing, toilet use and personal hygiene, extensive assistance of 1 with transfer and physical help in part of bathing activity with assistance of 1. On 03/17/2021 review of Resident #10's Clinical Record revealed the following: Review of Resident #10's Comprehensive Care Plan revealed the following: Resident receives dialysis treatments 3 times weekly. ESRD (End Stage Renal Disease). Date Initiated: 12/15/2020 Created on: 12/15/2020 Revision on: 12/15/2020. Review of Resident #10's Order Summary Report on 03/17/2021 at approximately 2:10 p.m., revealed the following date: Active Orders As Of: 03/01/2021. Review of Order Summary Report did not evidence an order for Dialysis. On 03/18/2021 review of Resident #10's Medication Administration Record for the period of 03/01/2021 - 03/31/2021 did not evidence an order for dialysis. On 03/18/2021 review of Resident #10's Treatment Administration Record for the period of 03/01/2021 - 03/31/2021 did not evidence an	F 698	**F698** **Corrective Action(s):** Resident #10's physician notified, order clarified. Care plan reviewed and revised to reflect dialysis scheduled days. **Identification of Deficient Practices/Corrective Action(s):** Current residents who receive dialysis have the potential to be affected by this deficient practice. Audit of dialysis residents' clinical record reviewed for current orders for dialysis and scheduled days by DON/designee, any are of concern corrected. **Systemic Change(s):** Licensed Nurses educated on obtaining and ensuring orders are present for dialysis to include the scheduled days by DON/designee. New employed licensed nurses will be educated on process. **Monitoring:** Dialysis residents audited weekly for 12 weeks by Unit Manager/designee to ensure order is correct. Results of audit taken to QAPI monthly for 3 months for review and revision as necessary. **Completion Date: 4/15/2021**	4-15-21

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F 698	Continued From page 67 order for dialysis. On 03/18/2021 at approximately 3:45 p.m., at pre-exit meeting the Administrator, Director of Nursing and Regional Vice President of Operations was informed of the finding. When asked should the resident have an order for dialysis, Director of Nursing stated, "Yes should have the order." When asked who obtains the order, "The nurse." When asked what are your expectations of the nurses, Director of Nursing stated, "Expect them to follow up to get the order." The facility did not present any further information about the finding.	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		

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F 755	Continued From page 68 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview the facility staff failed to acquire medications upon admissions for one resident (Resident #258) in the survey sample of 36 residents. The findings included: Resident #258 was admitted to the facility on 06/03/20. This resident was diagnosed as having Tardue Dyskinesia, hypertension, anxiety, depression, Bipolar, Schizoaffective disorder, hyperlipidemia, and anemia. The facility staff failed to acquire medications upon admissions for Resident #258. This resident was assessed being stand to pivot x 1 assist, alert and oriented times 1 to self. Resident noted to wander in other patient rooms and exit seeking. A wander guard placed on left ankle. Resident #258 had a physician's order dated 06/03/20 for the following medications: "Alendronate 35 milligrams (mg) tablet (1 tablet) oral one time weekly starting 06/03/20:	F 755	**F755** **Corrective Action(s):** Resident #258's attending physician notified of delay in medication delivery on admission. No apparent concerns at this time. **Identification of Deficient Practices & Corrective Action(s):** Audit of admissions for past 30 days for medication availability and any delay in medication delivery by DON/designee. Areas of concerned addressed. **Systemic Changes:** Licensed nurses educated by DON/designee on Medication not available process. New employed licensed nurses will be educated on the process as part of orientation. **Monitoring:** New admissions/readmissions will be reviewed 5 times a week for 12 weeks by DON/designee to ensure medications are received timely. Results of audits will be taken to QAPI monthly for 3 months for review and revision as needed. **Completion Date: 4/15/2021**	4-15-21

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	495287	A. BUILDING _____ B. WING _____	C 03/18/2021

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F 755	Continued From page 69 Latanoprost 0.005% eye drops (1 drop) drops both eyes one time daily starting 06/03/20: Clonazepam 2 mg tablet (1 tablet) tablet oral two times daily starting 06/03/20: Ferrous sulfate 325 mg (65 mg iron) tablet (1 tablet) tablet oral two times daily starting 06/03/20: Risperdal 0.5 mg tablet (1 tablet) tablet oral two times daily starting 06/03/20: Risperdal 1 mg tablet (1 tablet) tablet oral two times daily starting 06/03/20: Amlodipine 10 mg tablet (1 tablet) tablet oral one time daily starting 06/04/20: Escitalopram 10 mg tablet (1 tablet) tablet oral one time daily starting 06/04/20:" A review of the Medication Administration Record June 2020 Non-PRN Medication Notes indicated: "Clonazepam 2 mg tablet (1 tablet) tablet oral two times daily - Date 06/03/20 - Time 2100 (9:00 P.M.) Notes- Not administered (Med not available). A 06/04/20 note indicated: Time- 9:00 A.M. -Notes - Not administered (Med not available)." During an interview on 03/18/21 at 9:07 A.M. with the Director of Nursing (DON) she stated, Resident #258 did not receive her prescribed Clonazepam 2 mg medications on 06/03/20 and 06/04/20 was because the meds were not available.	F 755		

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F 755	Continued From page 70 A facility Pharmacy Services policy "Medication shortages/Unavailable Medications" indicated: Procedures: "1. Upon discovery that facility has an inadequate supply of a medication to administer to a resident, facility staff should immediately initiate action to obtain the medication from pharmacy. If the medication shortage is discovered at the time of medication administration, facility staff should immediately take the action specified in Sections 2 or 3 of this policy as applicable. 2. If a medication shortage is discovered during normal pharmacy hours: 2.1 Facility nurse should call pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply facility staff should notify pharmacy and arrange for an emergency delivery. 3. If a medication shortage is discovered after normal pharmacy hours: 3.1 A licensed facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include:	F 755		

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F 755	Continued From page 71 3.2.1 Emergency delivery: or 3.2.2 Use of an emergency (back-up) third party pharmacy. 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions." During an interview on 03/18/21 at 9:07 A.M. with the DON she stated, " The Stat Box information was not available for review because of a lack of access with the prior owner's of the facility." The facility staff failed to acquire medications upon admission to the facility for one resident. Based on resident interview, staff interviews and review of facility documents, the facility's staff failed to consistently procure an ordered significant medication for 1 of 36 residents (Resident #50), in the survey sample. The findings included Resident #50 was originally admitted to the facility 12/3/14 and readmitted 2/22/21 after an acute care hospital stay. The current diagnoses included; Multiple sclerosis (MS). The significant change Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/27/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #50's cognitive abilities for daily decision making were intact. An interview was conducted with Resident #50 on 3/16/21 at approximately 12:40 p.m. Resident	F 755		

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F 755	Continued From page 72 #50 stated frequently his Multiple Sclerosis medication Glatiramer 20 milligram/1 milliliter subcutaneously is not available for administration. The resident further stated he wasn't sure why the staff allowed it to run out prior to obtaining more. The physicians order dated 12/15/20 read; Glatiramer 40 milligram/1 milliliter subcutaneously one time per day on Monday, Wednesday and Friday, for MS. On 2/24/21, the order was resumed after the resident returned from the hospital. Review of the pharmacy invoices provided revealed the pharmacy delivered a one week supply (3 one dose syringes) of the medication to the facility 12/23/20 and doses were administered 12/25/20, 12/28/20 and 12/30/20, Three more doses were delivered 12/28/20 to be administered 1/1/21, 1/4/21 and 1/6/21, Three more doses were delivered 1/7/21 and administered 1/8/21, 1/11/21 and 1/13/2, Three more doses were delivered 1/15/21 and were administered 1/15/21, 1/18/21 and 1/20/21, Three more doses were delivered 1/20/21 and were administered 1/22/21, 1/25/21 and 1/27/21, there was no medication available to administer 1/27/21 and 1/29/21 for the next three more doses were not delivered until 2/3/21, they were administered 2/3/21, 2/5/21 and 2/8/21, there was no medication available to administer 2/10/21, Three more doses were delivered 2/12/21, they were administered 2/12/21, 2/15/21 and one left for 2/17/21 but the resident was admitted to the hospital on 2/16/21. An interview was conducted with Licensed Practical Nurse (LPN) #2 on 3/18/21 at	F 755		

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F 755	Continued From page 73 approximately 1:45 p.m. LPN #2 stated there has been occurrences in which the resident's medication Glatiramer had been delivered late to the facility or not available to administer at all but less frequently than previously. On 3/18/21 at approximately 3:30 p.m., the above findings were shared with the Administrator, Director of Nursing and Corporate Consultant. The Director of Nursing stated she would look further into the allegation and provide documentation after it was obtained. Pharmacy invoices for the medication Glatiramer 40 milligram/1 milliliter were requested from 11/1/21 through the last delivery 3/16/21. Invoices for three doses were provided for 11/18/20, 11/30/20, 12/6/20 .	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761	**F761** **Corrective Actions(s):** Expired items cited removed 3/17/2021. **Identification of Deficient Practices & Corrective Action(s):** Current residents have the potential to be affected by this deficient practice. Medication carts, treatment carts and medication rooms were audited and any areas of concern were addressed. **Systemic Changes:** Licensed nursing staff educated on proper labeling and storage of medications, treatments and treatments supplies by DON/designee. New employed licensed nurses will be educated as part of orientation. **Monitoring:** Medication rooms, medication carts and treatment carts will be audited weekly for 12 weeks by Unit Manager/designee to ensure appropriate storage, labeling and no expired items. Results of audits will be taken to QAPI committee monthly times 2 months for review and revisions as needed. **Completion Date: 4/15/2021**	4-15-21

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F 761	Continued From page 74 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on the observation of 2 medication carts, 1 treatment cart and 1 medication room; the facility staff failed to dispose of expired medications and surgical supplies for two units. The facility staff failed to dispose of expired medications on Unit 1 and failed to discard two expired suture trays on unit 2. The findings include: On 3/17/21 at 11:09 AM an Inspection of Treatment Cart on Unit 2 was conducted with LPN (Licensed Practical Nurse) #4. Two suture removal Tray kits with an expiration date of 11/01/2020 was found during the inspection. LPN #4 replied, "I should have discarded them." On 03/17/21 at 2:11 PM on unit 1 an inspection of medication cart #1 was conducted with LPN #3. Upon visual inspection a house stock bottle of acetaminophen 500 mg with an expiration date of 1/2021 was seen. It had an opened date of 3/08/21. Located in the same medication cart was 1 bottle of Humalog insulin with an open date of 2/10/21. LPN #3 stated, "I meant to take it out this morning. It's over twenty eight days. I should have discarded the insulin and Tylenol."	F 761		

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F 761	Continued From page 75 Numerous attempts were made to obtain a policy/policies on expired medications and biologicals from the facility administrator. An exit interview was conducted on 3/18/21 at 2:28 PM with with the Regional Vice President of Operations (Corporate Staff #3) No comments were voiced.	F 761		
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, 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;	F 842	**F842** **Corrective Actions(s):** Resident # 27's physician notified of omissions on treatment record. Resident #27 no longer a resident in facility; discharged 3/24/2021. **Identification of Deficient Practices & Corrective Action(s):** Current residents receiving medication and/or treatments have the potential to be affected by this deficient practice. Review of medication/treatment administration records for Month of March by DON/designee for any concerns. **Systemic Changes:** Licensed nurses will be educated on medication/treatment accurate documentation by DON/designee. New employed licensed nurses will be educated as part of orientation. **Monitoring:** Audits of Medication and treatment administration records will be done 5 times a week for 12 weeks for completion by DON/designee. Results of audit will be taken to QAPI monthly times 3 months for review and revisions as needed. **Completion Date: 4/15/2021**	4-15-21

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F 842	Continued From page 76 (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 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	F 842	**F842** **Corrective Actions(s):** Resident # 27's physician notified of omissions on treatment record. Resident #27 no longer a resident in facility; discharged 3/24/2021. **Identification of Deficient Practices & Corrective Action(s):** Current residents receiving medication and/or treatments have the potential to be affected by this deficient practice. Review of medication/treatment administration records for Month of March by DON/designee for any concerns. **Systemic Changes:** Licensed nurses will be educated on medication/treatment accurate documentation by DON/designee. New employed licensed nurses will be educated as part of orientation. **Monitoring:** Audits of Medication and treatment administration records will be done 5 times a week for 12 weeks for completion by DON/designee. Results of audit will be taken to QAPI monthly times 3 months for review and revisions as needed. **Completion Date: 4/15/2021**	4-15-21

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F 842	Continued From page 77	F 842		

and clinical record review, it was determined that facility staff failed to maintain a complete and accurate clinical record for one of 36 residents in the survey sample, Resident #27.

The findings included:

1. Resident #27 was admitted to the facility on 02/10/2021. Diagnosis included but were not limited to, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side and Type 2 Diabetes Mellitus. Resident #27's Admission Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 02/13/2021 was coded with a BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #27 as requiring total dependence of one person with bed mobility, transfer, dressing, toilet use, personal hygiene and bathing and supervision with setup help only for eating.

On 03/17/2021 Resident #27's Clinical Record was reviewed and revealed the following:

Review of Physician Order Summary revealed that Resident #27 has an order for a treatment to the Sacrum clean with NS (Normal Saline), pat dry, apply Dakins soaked gauze packed into wound and bordered dry dressing BID (Twice a Day) and PRN (As Needed) every day and night shift. Order Date: 02/10/2021 Start Date: 02/10/2021. Review of Treatment Administration Record (TAR) for the period of 2/1/2021 - 2/28/2021 revealed the following dates with blank spaces: Day E 2/12, 2/13, 2/14, 2/15, 2/16, 2/20, 2/21, 2/23, 2/24, 2/25, 2/27/2021; Night

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F 842	Continued From page 78 2/10, 2/13, 2/26. Review of Treatment Administration Record for the period of 3/1/2021 - 3/31/2021 revealed the following dates with blank spaces: Day E 3/2, 3/5, 3/10, 3/11, 3/13. On 03/18/2021 at approximately 9:30 a.m., an interview was conducted with the Unit Manager. When asked what do blank spaces indicate on the Treatment Administrative Records, Unit Manager stated, " Either not signed out or hit Other. If the nurse does not sign out, initial, space will be blank." On 03/18/2021 at approximately 10:45 a.m., an interview was conducted with the Director of Nursing. The blank spaces on the Treatment Administrative Records for February 2021 and March 2021 were reviewed with the Director of Nursing. When asked if something should be documented in the blank spaces on the Treatment Administrative Records, Director of Nursing stated, "Yes, if there is a blank and no key it makes me question. Can't answer for them or her." The Administrator, Director of Nursing and Regional Vice President of Operations were informed of the finding on 03/18/2021 at approximately 3:45 p.m. at the pre-exit meeting. The facility did not present any further information about the finding.	F 842		
F 868 SS=D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i) §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:	F 868		

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F 868	Continued From page 79 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and facility documentation the facility staff failed to have the required minimal committee members attend QAA meetings and failed to meet on a quarterly basis. The findings included: On 3/18/21 at approximately 11:16 AM, a review of the facilities QA/QAPI Plan was conducted and findings were discussed with the Administrator, DON (Director of Nursing), The Regional Director of Operations and The Regional Director of Clinical Services. A review of the QAPI Plan signature page revealed that the Medical Director/designee did not attend the required amount of meetings on the following meeting dates: 2/18/20, 5/21/20 and 5/28/20. The QAPI Plan also revealed that the required quarterly meetings were not conducted. The meetings were conducted on the following dates: 2/18/20, 5/21/20, 5/28/20, 11/30/20 and 2/26/21. No quarterly meetings were conducted in August 2020. (This should have been the 3rd quarterly	F 868	**F868** **Corrective Actions(s):** Administrator was educated 3/18/2021 on the regulation/requirements related to QA meetings and minutes by RVPO **Identification of Deficient Practices & Corrective Action(s):** Current residents have the potential to be affected by this deficient practice. **Systemic Changes:** Education to Administrator and Medical director completed by the Regional Vice President of Operations on the QA process and expectations. **Monitoring:** RVPO auditing QAPI minutes monthly for 3 months to ensure expectations are being met. Results of audits taken to QAPI meeting monthly for 3 months for review and revisions as needed. **Completion Date: 4/15/2021**	4-15-21

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F 868	Continued From page 80 meeting). The VP (Vice President) of Regional Operations stated, "We purchased the nursing home in November 2020." Policy: Quality Assurance and Performance Improvement (QAPI) Program Policy. Effective: 11/28/17. Last Revision Date: 5/28/2020. QAPI efforts are a component of the facility QAA (Quality Assessment and Assurance) committee's responsibilities. The QAA Committee is responsible for both Quality Assessment and Assurance activities (QA) and ongoing, proactive, performance improvement (PI) activities. QAPI represents the merger of these two processes. The purpose of QAPI in the facility is to take a proactive approach to continually improving delivery of care and services and to engage residents, caregivers, and other clinical/operational partners in maximizing quality of life and quality of care. The facility will maintain a QAPI Committee consisting, at a minimum, of: (A) The administrator. (B) The Director of Nursing Services. (C) The Medical Director or his/her designee. (D) The designated Infection Preventionist. (E) Direct Care Staff on a rotating basis. (F)Staff from ancillary departments on a rotating basis. (G) At least two other members of the facility staff. The Committee will meet at least quarterly, and as needed, to coordinate and evaluate activities of the QAPI program/plan. This includes development and implementation of action plans to correct opportunities for improvement and regular review and analysis of data collected under QAPI program/plan. An exit interview was conducted on 3/18/21 at 2:28 PM with the Vice President of Regional	F 868		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMPTON HEALTH & REHAB CENTER, LLC	2230 EXECUTIVE DRIVE HAMPTON, VA 23666

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 81 Operations (Corporate Staff #3). No further comments were made.	F 868		