STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	C 03/23/2021

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

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/21/2021 through 03/23/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/21/2021 through 03/23/2021. One complaint was investigated during the survey. VA00051155 was substantiated with deficient practice. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow. The census in this 60 certified bed facility was 45 at the time of the survey. The survey sample consisted of twelve (12) current resident reviews, and two (2) closed record reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		4/26/21

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

Electronically Signed | 04/06/2021

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F 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on staff interview, family interview, clinical record review, facility document review and in the course of a complaint investigation, the facility staff failed to ensure one of 14 residents (Resident #2) was free from neglect. Facility staff failed to get an order for a urinalysis for Resident #2 after a request by the family. Resident #2, who had a history of urinary tract infections, subsequently was admitted to the hospital and treated for a urinary tract infection a week later. Findings include: Resident #2 was admitted to the facility on 02/26/19, with the most current readmission on 03/07/21. Diagnoses for Resident #2 included, but were not limited to: dementia, high blood pressure, history of stroke with left side hemiparesis/hemiplegia, depression, psychotic disorder, history of nausea with vomiting and UTI (urinary tract infection). The most current MDS (minimum data set) was a quarterly review dated 12/31/20. This MDS assessed the resident as having long and short term memory impairment and modified impairment in daily decision making skills. This MDS assessed the resident as requiring extensive assistance from staff for all ADLs (activities of daily living). The resident also had a five day medicare MDS dated 03/13/21. This MDS assessed the resident with a cognitive score of 9, indicating the resident had moderate impairment in daily decision making skills. The resident was assessed as	F 600	F600 No action was taken due to time frame had already passed. Current residents have the potential to be affected. Current clinical staff will be educated by the Director of Nursing/designee on ensuring notifying the physician on family request regarding care at the time the request is made. In addition, education also included placing residents on the doctor's rounding sheets when family makes request for care that involves the provider. Department heads will also be educated when families make requests to ensure these are brought to the attention of the Chief Administrator Officer/Director of Nursing at the time of the request to ensure proper follow up. The Director of Nursing/designee will review in clinical meeting 5x weekly documentation to ensure decline in resident's status has been reported to the provider and placed on the provider rounding form. In addition, any family/resident concerns will be discussed during the morning meeting and follow up completed. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial	

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F 600	Continued From page 2 having a UTI in the last 30 days. The complaint alleged that on 02/22/21 a window visitation was conducted between the son and Resident #2, and the son noticed the resident had a "change in demeanor" and was concerned. The son reported this information, communicated with facility staff, and asked for the resident to be seen by the physician regarding his concerns. According to the complaint the son was concerned that the resident may have a UTI. The facility submitted a Facility Reported Incident (FRI) to the State Agency regarding this concern. Resident #2 was a current resident of the facility. The resident was observed on multiple occasions and multiple attempts were made to interview the resident during the survey process. Resident #2 only spoke a few words at a time and stated that she did not remember going to the hospital. On 03/22/21, the administrator was asked for any documentation, investigation and/or follow up related to the FRI dated 03/01/21. The investigation included the following statement dated 03/01/21 from the AD (Activity Director), "...02/22/21...6:00 - 6:30 PM...I spoke with [name of Resident #2's son] while I was outside setting up chairs for a window visit with him and his mother. Two other family members were there. He told me that this mother seemed confused when he spoke to her on the phone earlier that week. He said that her confusion could indicate a UTI and he would like to have her checked for a UTI. I reported what he said to the nurse [Name of nurse/identified as Registered Nurse #1]." A statement dated 03/04/21 from RN #1	F 600	compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis. The CAO/DON is responsible for implementation of the plan of correction.	

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F 600	Continued From page 3 documented, "Was stopped by [name of Resident #2's son] after my shift had ended and was told that he wanted a U/A [urinalysis] for his mother. I told him I would put her on the doctor's book. I intended to do this in the AM when I came into work but was sick and called out." Resident #2's nursing notes were reviewed from 02/19/21 [prior to the window visit] through 03/01/21 [the date the resident went to the hospital]. The nursing notes revealed the following: 2/19/2021 [5:11 AM] "...Resident awake, vomited undigested food. Staff in to change gown and bed. Am meds provided. Will monitor and assess [signature RN #3]." 2/19/2021 [12:17 PM] "...Promethazine HCl Tablet 25 MG Give 1 tablet by mouth every 6 hours as needed for an/v [nausea/vomiting] 60cc dark yellow syrupy emesis [signature of RN #1]." 2/19/2021 [3:21 PM] "...eMAR...Promethazine HCl Tablet 25 MG [milligrams] Give 1 tablet by mouth every 6 hours as needed for n/v PRN [as needed] Administration was Effective Resident up in a chair and emesis has stopped for now [signature of RN #1]." 2/19/2021 [5:00 PM] "...eMAR...Notified RP [responsible party] and MD [medical doctor] of emesis. Resident vomited approx. 60 cc x 3 this am of the same type fluid but is feeling better after the Phenergan. Resident is drinking tea and is looking forward to dinner. Resident is afebrile. No other symptoms noted. Will continue to observe [signature of RN #1]."	F 600		

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F 600	Continued From page 4 2/26/2021 [1:07 PM] "...Resident received COVID vaccine yesterday. No adverse reactions noted. Tolerating well [signature of LPN #4]." 2/27/2021 [2:15 AM] "...Resident continues to be under skilled services...A&O [alert and oriented] x 2...mucous membranes are pink, moist, and intact...Speech is clear...can voice needs. Lungs clear...No cough, or SOB [shortness of breath] noted or voiced...Abdomen is soft and non distended...Bowel sounds present...has no complaint of pain or discomfort...Took meds whole w/o [without] difficulty...Rsd [resident] experienced fever and vomiting during shift, Rsd given 25mg/ml Phenergan and started on clear liquid diet per standing orders. [name of NP/nurse practitioner] informed of rsd symptoms [signature of RN #2]." A late entry nursing note dated effective for 2/27/2021 10:30 PM [creation date: 03/05/21 11:09 PM] documented, "...Nurse observed rsd with emesis on chest/face/hair. Assessed rsd and low grade temp of 99.5 was noted. Rsd was given a shower due to emesis. Approx 30 min after initial temp was assessed, a normal temp of 98.6 was noted. Temp was assessed throughout the night and remained with normal limits. NP was notified of rsd condition and that rsd was started on standing orders [signature of RN #2]" 2/28/2021 9:27 AM "...Resident continues to be under skilled services at this time. A&O to self...mucous membranes are pink, moist, and intact...Speech is clear. Rsd can voice needs. Lungs clear...No cough, or SOB noted...no complaint of pain or discomfort...Took meds w/o difficulty or adverse effects [signature of LPN #1].	F 600		

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F 600	Continued From page 5 3/1/2021 9:08 AM "...Resident continues...A&O x 2....mucous membranes are pink, moist, and intact...Speech is clear...can voice needs. Lungs clear...No cough, or SOB noted or voiced...abdomen is soft and non distended. Bowel sounds present....no complaint of pain or discomfort...Took meds w/o difficulty...[signature of LPN #1]." 3/1/2021 12:50 PM "Discharge/Transfer Summary Note...altered mental status, clammy, sweaty, diaphoretic...decreased level of consciousness, clammy. BS [blood sugar] checked 202...resident was lethargic sternal rub performed with minimal response from resident...MD aware...blood Pressure: BP 90/70...Temperature: 98.6... Pulse: 101...Regular...Respiration: 16...O2 Sats: 94 %... [signature of LPN #1]." Resident #2's comprehensive care plan dated 11/02/20 (prior to resident's discharge) documented, "...Resident is incontinent of urine...resident will remain as clean and dry as possible...Check and change frequently as needed...Observe for changes in urine characteristics for s/s [signs or symptoms] of an urinary infection...administer medications as ordered..." On 03/22/21 at 3:45 PM, the AD was interviewed. The AD stated that she remembered that day and stated that she had got him [the son] set up with the window visit and he voiced that he was concerned that his mother was confused and he wanted her to be seen by the doctor and that the confusion may indicate the resident is getting a UTI. The AD stated, "After I got him [son] set up,	F 600		

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F 600	Continued From page 6	F 600		

I went in to the nurse and told her what the family had said and that he wanted her to be checked." The AD stated that RN #1 told her, "I can't just do a check like that, I have to get an order." The AD then stated that the doorbell to the facility rang and she left the nurse and went to answer the door. The AD was asked if RN #1 was working today. The AD stated that she had not seen RN #1 in about a week.

On 03/22/21 at approximately 3:50 PM, the ADON (assistant director of nursing) stated that RN #1 no longer worked at the facility and her last day was on March 9th, 2021.

On 03/22/21 at 4:00 PM, the administrator, DON (director of nursing), ADON and the CNO (chief nursing officer) were made aware of the concerns regarding Resident #2 and the above information. The CNO stated that RN #1 denied that the AD reported anything to her regarding Resident #2. The administrative staff were made aware that RN #1 was made aware by the resident's son, according to RN #1's statement taken on 03/04/21.

On 03/23/21 at 8:45 AM, Resident #2's son was interviewed. The resident's son stated that he spoke with RN #1 on the evening of 02/22/21 around 6:30 PM and informed her of his concerns regarding Resident #2. The resident's son stated that RN #1 assured him it would be taken care of the next day, when the RN returned to work. The resident's son stated that according to the facility, RN #1 was sick the following day and did not return to work until several days later.

On 03/23/21 at 10:50 AM, the NP (nurse practitioner) was interviewed. The NP stated that

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F 600	Continued From page 7 she did not remember being called about Resident #2 on 02/27/21 by RN #2. The NP stated that, nausea and vomiting were not uncommon for Resident #2 and stated that the resident was on multiple stomach medications. The NP stated if a resident is put on the book by nursing, the resident would been seen on the next physician's visit. On 03/23/21 at 1:00 PM, RN #2 was interviewed regarding the note written on 02/27/21 at 2:15 AM. The RN stated that she called the NP and reported concerns and did what was ordered. RN #2 stated that she did not put her on the book to be seen by the physician, as this wasn't uncommon for this resident and that the NP was called. Hospital records for Resident #2 were reviewed. The ER [emergency room] note documented, "...presents to the ED [emergency department] from NH [nursing home]...a report form NH staff of altered mental status. Per the report from NH...pt was difficult to arouse and confused...On arrival to the ED, pt is alert and in no apparent distress. She is able to answer questions and follow commands...denies any complaints..." The resident was admitted to the hospital for UTI, treated with IV medications and fluids and discharged back to the facility on 03/07/21. No further information and/or documetnation was presented prior to the exit conference on 03/23/21 at 3:30 PM. This is a complaint deficiency.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		4/26/21

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F 610	Continued From page 8 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on resident interview, clinical record review, facility document review and staff interview, the facility staff failed for one of 14 residents to conduct a complete and thorough investigation for an injury sustained during an altercation between a resident and a staff member. Resident #7 sustained a large bruise covering the left eye. The Findings Include: Resident #7 was admitted to the facility on 3/25/20. Diagnoses for Resident #7 included: Dementia with behaviors, mild cognitive impairment, impulse disorder, and chronic obstructive pulmonary disease. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference	F 610	F610 An FRI (Facility Reported Incident) was completed and send to the appropriate agencies for Resident #7 on 3/23/2021. A review of the incident/accident reports was reviewed during the last 30 days to ensure reporting requirements were met and investigations were complete. The Chief Administrative Officer and Nursing Administration will be educated by the Chief Nursing Officer/designee on the center's policy for abuse and neglect and to ensure investigations are thorough and complete including taking a statement from the resident.	

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F 610	Continued From page 9 date) of 3/12/21. Resident #7 was assessed with a cognitive score of 14 indicating cognitively intact. On 03/21/21 at 11:24 AM, Resident #7 was interviewed. During the interview Resident #7 was observed with a fading bruise surrounding the left eye. When asked about the bruise Resident #7 said a woman hit him about 2 weeks ago. Resident #7 was asked if the bruise was caused by a staff member. Resident #7 nodded yes but did not give anymore information. On 3/22/21 Resident #7's clinical record was reviewed. A progress note documented "3/17/2021 21:53 [11:53 PM] Nurse's Note Note Text: Was alerted by other nurse that Resident tried hitting her and struck her elbow, which deflected resident hand and he struck himself in the L [left] eye. Resident assessed, redness and some swelling noted to L eyelid along with a 1 cm scratch. Resident denies pain discomfort to area. Resident PERRLA. Speech clear. Resident alert and oriented to self usual level of orientationhe [SIC] " On 3/22/21 at 1:44 PM, the administrator was interviewed and was asked if a FRI (Facility Reported Incident) had been sent to the State Agency regarding Resident #7's bruised eye. The administrator said a FRI had not been sent because the facility knew how the bruise was acquired. The administrator was told that during an interview with Resident #7, Resident #7 stated that a staff member hit him. The administrator stated "That's the first time I have heard that." On 03/22/21 at 2:30 PM an interview with the ADON (assistant director of nursing) took place.	F 610	The Chief Administrative Officer/designee will review in clinical meeting the incident/accident reports to ensure any injury is thoroughly investigated including statements from the resident. The results will be reported to the monthly Quality Committee for review and discussion To ensure substantial compliance. Once the QA Committee determines the problem no long exists, the review will occur on a random basis. The CAO/DON are responsible for implementation of the plan of correction.	

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F 610	Continued From page 10	F 610		

The ADON said Resident #7 has behavior issues and a nurse was working as a CNA (certified nurse assistant) and was giving Resident #7 a bath, Resident #7 became combative and started trying to punch the nurse and while throwing punches Resident #7's fist deflected off the nurses elbow and he hit himself in the left eye. The ADON was asked to present all investigation documentation.

A witness statement documented " [name of staff member involved, identified as LPN #3] incident date and time 3/17/21 at 9:00 PM [documented by LPN #3] Resident went to hit me in the face while I was showering him. When he hit my left elbow his fist came back hitting him on the left brow.

Immediate intervention: Told [name of LPN, identified as LPN #2] about incident came in and assessed. Denied pain. Fingernail caused a little cut on brow. [signature of LPN #3 and interviewer ADON]."

On 03/23/21 at 9:46 AM, the ADON was interviewed regarding witness statements. The ADON stated, LPN #3 was the only witness, LPN #2 did an investigation with LPN #3 at the time of the incident and said Resident #7 was on a shower bed and LPN #3 was standing above Resident #7 shaving him when Resident #7 hit LPN #3's arm deflecting off the arm hitting himself in the face. The ADON said that the physician and guardian were notified.

On 3/22/21 review of Resident #7's most recent "Nursing Monthly Summary" dated 3/6/21 documented Resident #7's mental status as being "Alert [and] Able to fully express self and

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F 610	Continued From page 11 understand others [...]" Resident #7's care plan was also reviewed and did evidence that Resident #7 had behaviors that included throwing meal trays, yelling and cursing at staff, and trying to strike out at staff. According to Resident #7's most recent MDS with an ARD of 3/12/21 under section G0120 "Bathing" Resident #7 is coded as total dependant on staff with 2 plus physical assistance from staff. On 03/23/21 at 10:27 AM, the ADON was asked about not getting a statement from Resident #7. The ADON said there was no rational for not getting a resident statement, she thought LPN #2 asked him what happened but Resident #7 said he didn't know what happened. On 03/23/21 at 10:36 AM, the ADON said herself along with the DON assessed Resident #7 on 3/18/21 and during the assessment Resident #7 was asked what happened and Resident #7 said he did not know. It was explained to the ADON that nothing about this was documented in the clinical record. The ADON said, she would put the information as a late entry. The late entry was reviewed and was dated for 3/18/21 and entered on 3/23/21 and read '[...] asked resident what happened to his eye. resident [sic] states he didn't know and for us to get out of his room." Review of the facilities abuse policy in regards to investigation read in part "Designated staff will immediately review and investigate all allegations or observations of abuse. [...] The organization will conduct analysis for trends and patterns	F 610		

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(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 610	Continued From page 12 related to incidents [i.e. falls, skin tears, bruising or injury of unknown origin, unusual occurrences, reportable incidence.]." On 03/23/21 at 02:43 PM, during a facility staff meeting, the above information was presented to the administrator, DON, ADON, and chief nursing officer (CNO). The CNO stated the facility knew what had happened and felt their investigation was completed. The ADON stated that she would try to get the nurses that were involved on the phone for an interview. On 03/23/21 at 03:06 PM, LPN #2 was interviewed via telephone. LPN #2 said she was at the nurses station and was called into shower room and nurse (LPN #3) working as a CNA (certified nursing assistant) said during Resident #7 being shaved he became combative and began swinging his arms, his fist deflected off LPN #3's elbow and hit himself in the eye. LPN #2 asked Resident #7 what happened, and he said my eye hurts. Attempt's were made to contact LPN #3, but was unavailable. No other information was presented prior to exit conference on 3/23/21.	F 610		
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- §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	F 622		4/26/21

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F 622	Continued From page 13	F 622		

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 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

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F 622	Continued From page 14 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) 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.	F 622		

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F 622	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure documentation regarding transfer was in the clinical record for one of 14 residents, Resident #45. Resident #45 was transferred to another skilled nursing facility; there was no documentation in the clinical record regarding coordination of care and service needs of the resident prior to her discharge. Findings were: Resident #45 was originally admitted to the facility on 10/08/2019 and most recently readmitted on 01/08/2020. Her diagnoses included, but were not limited to: COVID-19, hypertension, dementia with behavioral disturbances, osteoarthritis, incontinence, and depressive disorder. A quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/15/2021, assessed Resident #45 as having problems with both long and short term memory, as well as moderately impaired with daily decision making skills. The clinical record was reviewed on 03/22/2021 beginning at approximately 2:15 p.m. The progress note section on 02/12/2021, the following note was written: "15:33 [3:33 p.m.] Resident transferred to [Name of facility and Location]." There was no documentation of any coordination with the receiving facility regarding the resident's needs, nor was there any documentation showing the basis for the transfer.	F 622	F622 No action was taken due to the timeframe had already passed. A review of discharges/transfers from the past 30 days was completed to ensure the required documentation and the required elements was completed for the discharge/transfer. The Chief Administrative Officer and Nursing Administration will be educated by the Chief Nursing Office/designee on the policy for completing the documentation and ensuring the required elements are send with the residents on discharge/transfer. The Chief Administrative Officer/designee will review the in clinical meeting 5x weekly, residents who have been discharged/transfer to ensure the documentation is compete and the required elements have been send with the resident at the time of discharge. The results will be reported to the monthly Quality Committee for review and discussion To ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then review will occur on a random basis. The CAO/DON are responsible for implementation of this plan of correction.	

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F 622	Continued From page 16 The ADON (assistant director of nursing) was interviewed at approximately 3:30 p.m. She stated, "She was the only COVID resident we had left in the facility. [Name of Facility] still had a COVID unit so we transferred her there...we asked the resident and her son and they agreed." The ADON was asked if any of that information was documented anywhere. She stated, "I'm not sure...one of our social workers was working remotely. Let me see what I can find." The ADON reported back at approximately 3:45 p.m. She stated, "It looks like [name of the administrator] talked to the son... I have a "Notice of Transfer or Discharge" form that he filled out...it is checked that the transfer or discharge is necessary to meet the resident's welfare and the resident's needs could not be met in the facility...we transferred her down there but we expected her to come back...our policy is that if a resident is COVID positive they have to stay in isolation until they have two COVID tests that are negative...she had one that was negative, we transferred her down there until she could get the second negative and then we expected her to come back, but the family decided to keep her down there." An end of the day meeting was held with the DON [director of nursing], the ADON, the administrator and the Nurse Consultant on 03/22/2021 at approximately 4:00 p.m. The above information was discussed. They were asked how the receiving facility knew what to do with the resident regarding her care...The nurse consultant stated, "That is our sister facility...they have access to her records here...the whole record can be accessed from there...we've never done any kind	F 622		

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F 622	Continued From page 17 of documentation for a transfer to them...we sent her there because she was still testing COVID positive...I know the CDC says isolation for 14 days and you don't need to retest, but our policy is more stringent...we isolate for 14 days and then require two negative COVID tests before a resident comes out of isolation...The social worker was out with COVID so [name of the administrator] discussed the transfer by phone with the resident's son." The DON stated, "We were planning on getting her back, she was just transferred there because of COVID...we had to discharge her, and then when she came back we would do a new admission." At 4:55 p.m. the ADON called and stated, "We don't have a discharge summary, or a transfer summary, and I don't see any discharge planning...what we have is the notice of transfer/discharge...I'll get you a copy." The "Notice of Transfer or Discharge" was received and reviewed. The form was completed by the administrator on 02/12/2021 and contained the following: Resident's name, date of notice (02/12/2021), transfer/discharge date (02/12/2021), the name/location of the facility receiving the resident, the reason for transfer. "The transfer or discharge is necessary to meet the resident's welfare and the resident's needs could not be met in the facility", and the following statement was written at the bottom of the form: "Spoke with residents RP [responsible party] [Name] for transfer to [name of facility/location] for COVID recovery. Son is in agreement with the transfer with return to the [name of facility] when recovery is complete." No further information was obtained prior to the	F 622		

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F 622	Continued From page 18 exit conference on 03/23/2021.	F 622		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards during a medication pass and pour observation, for one of 14 residents, Resident #22.. License practical nurse (LPN #1) was going to give Resident #22 the wrong dose of Tylenol. The findings include: On 03/22/21 at 8:31 AM, during an observation of a medication pass and pour, LPN #1 began pulling medications out for Resident #22. One of the medications scheduled to be given was Tylenol. LPN #1 pulled a bulk bottle of Tylenol was observed and documented the dosage at 500 MG (milligrams) per tablet. Review of the electronic Medication Administration Record (MAR) documented to give 1000 MG. LPN #1 continued to dispense 4 Tylenol pills (equaling 2000 MG) into a medication cup along with other medications. LPN #1 then locked the cart and stepped away from the medication cart. LPN #1 was asked "Are you ready to give the medications." LPN #1 said "Yes." LPN #1 was then asked to stop and review the dosage on the	F 658	F658 Resident # 22 is receiving Tylenol as ordered by the provider. LPN #1 was immediately educated on the 5 R(s) of medication administration. Current residents in the center have the potential to be affected. Clinical staff was educated by the Director of Nursing/designee on the 5 R(s) of medication administration including administrating as per MD orders. Education included administration of over-the-counter medications and reading mg of pills vs total quantity in the bottle. The Director of Nursing/designee will observe two nurses per week during medication administration to ensure the five R(s) of medication administration is being completed with each med pass. The results will be reported to the monthly Quality Committee for review and	4/26/21

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F 658	Continued From page 19 bottle of Tylenol. After LPN #1 reviewed the dosage of Tylenol LPN #1 stated "I read that so wrong." On 03/22/21 at 09:10 AM, the ADON (assistant director of nursing) was aware of the above finding. Review of the physician order for Resident #22 documented "Tylenol tablet Give 1000 mg by mouth two times a day [...] Do Not exceed 3grams [...] in 24 hours." The start date of the Tylenol was dated 1/22/21. Review of the facilities policy for medication administration read in part " [...] Verify each time a medication is administered that it is the correct medication, at the correct dose [...]." On 03/22/21 at 04:02 PM, during an end of day facility staff meeting, the above information was presented to the director of nursing, administrator and chief nursing officer. No other information was presented prior to exit conference on 3/23/21.	F 658	discussion To ensure substantial compliance. Once the QA Committee determines the problem no longer exits, then reviews will be conducted on a random basis. The CAO/DON are responsible for implementation of the plan of correction.	
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	F 761		4/26/21

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F 761	Continued From page 20 §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 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 observation, staff interview and facility document review, the facility staff failed to ensure drugs and biologicals were stored properly in the facility's medication room. The facility failed to ensure an expired multi dose vial of influenza and a multi dose via of tuberculin were not available for administration; and failed to ensure a 30 ml bottle of Lorazepam concentrate belonging to a deceased resident, was not available for administration. Findings include: On 03/23/21 at 8:00 AM, the facility's medication room was observed with RN (Registered Nurse) #4. In the refrigerator was an opened multi dose vial of influenza, with an "open date" on the bottle and the box of 01/28/21.	F 761	F761 The expired medications from the med room were immediately discarded. The Ativan was discarded as per center policy. Current Residents in the center have the potential to be affected Current licensed nurses will be educated by the Director of Nursing/designee on ensuring expired medications are discarded and medications for discharged residents are returned to the pharmacy or discarded as per the center's policy. The Director of Nursing/designee will audit the medication room 3x weekly to ensure there are no expired medications and to ensure medications for discharged residents have been sent back to the	

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F 761	Continued From page 21 A multi dose vial of opened TB (tuberculin) was labeled with an "open date" of 01/10/21. The vial box was also labeled with the same date. A 30 ml bottle of Lorazepam concentrate was in the locked compartment of the refrigerator, the bottle had not been opened. The Lorazepam had a fill date of 01/11/21. RN #4 was asked if this resident was a current resident. RN #4 stated that she thought this resident had expired. RN #4 was asked why this medication was not returned to the pharmacy. RN #4 stated that she was not sure. Further review revealed that the Lorazepam concentrate belonged to a resident that expired on 01/11/21, the same date that the medication was filled. A policy was presented on drug storage by the ADON (assistant director of nursing) on 03/23/21 at 8:30 AM. The policy documented, "facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer...are stored separate ...until destroyed or returned to the pharmacy...staff record the calculated expiration date based on date opened...if a multi dose vial of an injectable has been opened or accessed...the vial should be dated and discarded within 28 days...facility should ensure that medications and biologicals for expired or discharged or hospitalized residents are stored separately, away from use, until destroyed or returned to the provider..." The administrator, ADON and DON (director of	F 761	pharmacy or discarded per center's policy. The results will be reported to the monthly Quality Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON are responsible for implementation of the plan of correction.	

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F 761	Continued From page 22 nursing) were made aware of the above on 03/23/21 at 11:30 AM, in a meeting with the survey team. No further information and/or documentation was provided prior to the exit conference on 03/23/21 at 3:30 PM.	F 761		