STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. BUILDING _____ B. WING _____	C 03/19/2021

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ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/16/2021 through 03/19/2021. 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 03/16/2021 through 03/19/2021. Three complaints were investigated during the survey. VA00051023 and VA00050313, were both unsubstantiated with no deficient practice identified. VA00050894 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 120 certified bed facility was 91 at the time of the survey. The survey sample consisted of nineteen (19) current resident reviews, and three (3) closed record reviews.	F 000		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to obtain physician orders for immediate care for one of 22 residents in the survey sample. Resident #142 had no physician orders upon admission for care of pressure ulcers, impaired skin integrity, and	F 635	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The	4/27/21

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

Electronically Signed | 04/08/2021

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F 635	Continued From page 1 monitoring of a dialysis access port. The findings include: Resident #142 was admitted to the facility on 3/12/21 with diagnoses that included pancreatitis, end stage renal disease with hemodialysis, depression, atherosclerotic heart disease, bullous pemphigoid, anxiety, diabetes, hypertension, atrial flutter, anemia and hip fracture. The admission assessment dated 3/12/21 assessed Resident #142 as alert, oriented to person with confusion and short-term memory problems. This assessment listed the resident as incontinent of bowel/bladder and as requiring physical assistance of two people for bed mobility and totally dependent upon staff for transfers. Resident #142's clinical record documented a skin assessment dated 3/12/21. This skin assessment documented the resident was admitted with a "catheter port" on his chest, a pressure ulcer on the right buttock, a pressure ulcer on the left buttock, a scab on the right front lower leg, a skin tear on the front of the left lower leg and blisters on the top of both feet. This assessment documented, "Dry skin noted throughout entire body." The section of this form documenting treatments was blank. Resident #142's clinical record documented no physician orders for care/treatment of the pressure ulcers, the skin tear, dry skin or the dialysis access port. There was a physician's order dated 3/12/21 for silver sulfadiazine cream 1% with instructions stating, "Apply to affected area topically every 12 hours as needed for Wound." This order failed to specify for which "wound" the silver sulfadiazine cream was	F 635	facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F635 1. Resident # 142 no longer resides in the facility. 2. Current residents who admitted in the last 7 days will be reviewed to ensure treatment orders for pressure ulcers and and dialysis access ports were initiated. 3. Licensed nursing staff will be educated regarding the need to initiate orders for pressure ulcers and dialysis access ports upon admission. Licensed nursing staff will ensure orders are in place for pressure ulcers and dialysis access ports upon admission. Nursing administration will review 10% of admissions weekly x 4 weeks to ensure accuracy of orders. Any issues will be corrected immediately at the time of identification. 4. Process will be reviewed in QS committee x 1 quarter. 5. 4-27-2021	

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F 635	Continued From page 2	F 635		

prescribed.

Resident #142's treatment and medication administration records dated 3/12/21 through 3/16/21 were reviewed. These records documented no treatments and/or dressings applied to the pressure ulcers, skin tear or dry skin. The medication administration record documented no application of the as needed silver sulfadiazine cream to any wound. The clinical record documented no monitoring of the resident's dialysis access port since the resident's admission on 3/12/21.

On 3/17/21 at 9:55 a.m., the licensed practical nurse (LPN #1) caring for Resident #142 was interviewed about any orders for care and/or monitoring of the resident's dialysis port. LPN #1 stated he was not sure where the resident's dialysis access port was located. LPN #1 reviewed the resident's clinical record and stated he found no physician orders regarding monitoring of the access port. LPN #1 stated a skin assessment dated 3/12/21 documented a "catheter port" on the resident's chest. Concerning any orders for monitoring of the site, LPN #1 stated, "I don't see any orders period." LPN #1 stated a dialysis access port was usually monitored for bleeding and to make sure the dressing remained intact. LPN #1 stated there were no orders entered regarding monitoring of the port and therefore no order was entered on the treatment record for ongoing monitoring of the site.

On 3/17/21 at 10:17 a.m., LPN #1 was interviewed about any admission orders regarding Resident #142's pressure ulcers and skin tear. LPN #1 reviewed the clinical record and stated he

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F 635	Continued From page 3	F 635		

found no orders regarding treatment of pressure ulcers or the skin tear. LPN #1 stated it was reported to him at shift change the resident had stage 2 pressure ulcers on his buttocks. LPN #1 stated he did not know what treatment or dressings were required for the pressure ulcers. LPN #1 stated there was an as needed order for the silver sulfadiazine cream to be applied to a "wound" but he did not know to which wound this was prescribed.

On 3/17/21 at 2:15 p.m., with the resident's permission and accompanied by LPN #1, Resident #142's skin was assessed. The resident had a dialysis access port on his right upper chest. The resident had an open wound on the upper right buttock adjacent to the sacral area. This wound was irregular shaped, approximately the size of a nickel with no visible depth. Below this wound was a second, smaller open area on the right buttock also irregular in shape. The wound beds were red with pink surrounding tissue. LPN #1 measured the open areas with the upper wound measuring 2.0 x 1.1 (length by width in centimeters) and the second wound measuring 0.8 cm x 0.6 cm with no measurable depth. The resident had on an incontinence brief with neither right buttock wound covered with a bandage or dressing. The resident had a scab on the front of his right shin, an open skin tear on the left shin, linear scabs on the right forearm and top of the left hand and scabs/dry skin on the top of both feet and lower legs. There were foam, adhesive dressings in place on the bottom of both heels. LPN #1 removed the dressings. The bottom of both heels had areas of irregular shaped black, dry, flaking skin with tan colored flaking skin in the center of each area.

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F 635	Continued From page 4 On 3/17/21 at 2:54 p.m., the director of nursing (DON) was interviewed about the lack of physician orders for skin care upon Resident #142's admission. The DON stated the charge nurse completed Resident #142's admission assessment on 3/12/21. The DON stated the admitting nurse was supposed to consult with the physician and obtain any needed orders for care/treatments based upon the assessment. The DON stated upon admission, care/treatment of skin issues and medications were a priority. On 3/18/21 at 8:15 a.m., the DON was interviewed again about any physician orders for immediate care of Resident #142's pressure ulcers and skin impairments. The DON stated the admitting nurse that assessed the pressure ulcers, skin tear and dry skin should have notified the physician and obtained orders for care. Concerning the dialysis access port, the DON stated the port was listed on the baseline care plan but no orders were obtained/entered for monitoring of the site for complications. This finding was reviewed with the administrator and director of nursing during a meeting on 3/17/21 at 3:45 p.m.	F 635		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure an	F 641	F641 1. Resident #9□s MDS was modified to	4/27/21

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F 641	Continued From page 5 accurate MDS (minimum data set) assessment for one of 22 residents in the survey sample, Resident #9. Findings include: Resident #9 was admitted to the facility on 05/22/19. Diagnoses for Resident #9 included, but were not limited to: CHF (congestive heart failure), PVD (peripheral vascular disease), history of stroke, dementia, malnutrition and depression. The most current MDS, a quarterly assessment dated 12/16/20 assessed the resident with a cognitive score of 7, indicating the resident had moderate impairment in daily decision making skills. The resident was also assessed as requiring limited assistance from at least one staff for most all ADLs (activities of daily living) and set up only for eating. This MDS also assessed the resident in Section K0300. as having a 5% weight loss in the last month or 10% weight loss in the last 6 months (not physician prescribed), and in Section K0310. assessed the resident as having a 5% weight gain in the last month or 10% weight gain in the last 6 months (physician prescribed). Resident #9's complete clinical records were reviewed and revealed that the resident had not had a weight loss or weight gain of 5% in the last month or 10% in the last 6 months. The resident's weight had remained stable (within a few pounds) for at least 18 month. On 03/17/21 at approximately 4:15 PM, the DON (director of nursing), administrator, and corporate nurse were made aware of the above information and was asked for clarification and/or any	F 641	include accruate documentation for weight loss in section K. 2. MDSCs will review current residents MDS assessments for section K to ensure accuracy of coding. Any issues will be addressed immediately at the time of identification. 3. MDSCs will alert administrator weekly x 4 weeks when a residents MDS assessment is complete by providing a copy of section K for verification of accuracy of coding. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021	

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F 641	Continued From page 6 additional information regarding the above. On 03/18/21 at 8:00 AM, the DON, administrator, and corporate nurse stated that the RD (registered dietitian) who completed Section K. for Resident #9 was no longer employed and that audits were being conducted on records that this RD had completed. No further information and/or documentation was presented prior to exiting the facility on 03/19/21.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		4/27/21

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F 655	Continued From page 7 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility failed to develop a baseline care plan for one of 22 residents in the survey sample, Resident #142. Resident #142's baseline care plan failed the include pressure ulcers, impaired skin integrity, fall/injury prevention, and anticoagulant use. The findings include: Resident #142 was admitted to the facility on 3/12/21 with diagnoses that included pancreatitis, end stage renal disease with hemodialysis, depression, atherosclerotic heart disease, bullous pemphigoid, anxiety, diabetes, hypertension, atrial flutter, anemia and hip fracture. The admission assessment dated 3/12/21 assessed Resident #142 as alert, oriented to person with confusion and short-term memory problems.	F 655	F655 1. Resident #142 no longer resides in the facility. 2. Current residents admitted in the last 7 days will be reviewed to ensure baseline care plans have been developed within 48 hours. Corrections will be made as necessary. 3. Licensed nursing staff will be educated regarding development of baseline care plans. Admitting nurse will initiate baseline care plan. Nursing leadership will audit 10% of admissions weekly x 4 weeks to ensure accuracy. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021	

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F 655	Continued From page 8	F 655		

This assessment listed the resident as incontinent of bowel/bladder and as requiring physical assistance of two people for bed mobility and totally dependent upon staff for transfers.

Resident #142's clinical record documented an admission skin assessment dated 3/12/21. The skin assessment dated 3/12/21 documented the resident had a pressure ulcer on the right buttock, a pressure ulcer on the left buttock, a scab on the right front lower leg, a skin tear on the front of the left lower leg and blisters on the top of both feet. This assessment documented, "Dry skin noted throughout entire body." The section of this form documenting treatments was blank.

The admission assessment dated 3/12/21 listed the resident had experienced a fall with a hairline hip fracture prior to admission.

The clinical record documented a physician's order dated 3/12/21 for the anticoagulant Heparin 5000 units/milliliter with instructions to administer 5000 units subcutaneously three times per day for 7 days to prevent blood clots.

Resident #142's baseline care plan initiated on 3/15/21 included no problems, goals and/or interventions regarding pressure ulcers, the skin tear, scabs, blisters, anticoagulant use or fall/injury prevention. The only care areas addressed on the baseline plan were contact-droplet precautions, renal failure/dialysis and nutrition.

On 3/17/21 at 10:17 a.m., the licensed practical nurse (LPN #1) caring for Resident #142 was interviewed about the plan of care for Resident #142's skin impairments. LPN #1 reviewed the

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F 655	Continued From page 9	F 655		

clinical record and stated he found no orders regarding treatment of pressure ulcers or the skin tear. LPN #1 stated it was reported to him at shift change the resident had stage 2 pressure ulcers on his buttocks. LPN #1 stated he did not know what treatments or dressings were required for the ulcers as there were no orders or plan of care. LPN #1 stated there was an as needed order for the silver sulfadiazine cream to be applied to a "wound" but he did not know for which wound this was prescribed. LPN #1 stated there was nothing on the care plan about wound/skin care.

On 3/17/21 at 2:15 p.m., with the resident's permission and accompanied by LPN #1, Resident #142's skin was assessed. The resident had a dialysis access port on his right upper chest. The resident had an open wound on the upper right buttock adjacent to the sacral area. This wound was irregular shaped, approximately the size of a nickel with no visible depth. Below this wound was a second, smaller open area on the right buttock also irregular in shape. The wound beds were red with pink surrounding tissue. LPN #1 measured the open areas with the upper wound measuring 2.0 x 1.1 (length by width in centimeters) and the second wound measuring 0.8 cm x 0.6 cm with no measurable depth. The resident had a scab on the front of his right shin, an open skin tear on the left shin, linear scabs on the right forearm and top of the left hand and scabs/dry skin on the top of both feet and lower legs. There were pink, foam adhesive dressing in place on the bottom of both heels. LPN #1 removed the dressings. The bottom of both heels had areas of irregular shaped black, dry, flaking skin with tan colored flaking skin in the center of each area.

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F 655	Continued From page 10 On 3/17/21 at 3:22 p.m., the director of nursing (DON) was interviewed about Resident #142's baseline care plan. The DON stated the admitting nurse was responsible for initiating the baseline care plan at the time of admission. The DON stated the baseline plan was expected to address basic and major care concerns. The DON stated she expected pressure ulcers and skin care to be part of a baseline care plan and that skin care and medications were a priority at the time of admission. This finding was reviewed with the administrator and director of nursing during a meeting on 3/17/21 at 3:45 p.m.	F 655		
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 observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice during medication administration for one of 22 residents, Resident #18. The findings include: Resident #18 was admitted to the facility on 07/24/2019. Diagnoses for Resident #18 included but was not limited to: Unspecified Dementia without behavioral disturbance, Heart	F 658	F658 1. Resident #18 is currently receiving medications administered by licensed nurses. 2. Current licensed nurses will be observed during a medication pass observation to ensure professional standards for practice during administration are met. Issues will be corrected immediately at the time of observation. 3. Licensed nursing staff will be	4/27/21

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F 658	Continued From page 11 failure, Chronic Atrial Fibrillation, Mild cognitive impairment, and Acute follicular conjunctivitis, left eye. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/24/20. Resident #18 was assessed with a cognitive score of 06 indicating severe cognitive impairment. On 3/16/2021 at 10:40 AM, upon entering Resident #18's room, a medicine cup with several pills in it and a bottle of prescription nasal spray were observed on resident #18's bedside table. When asked about the medications, Resident #18 stated she was waiting for someone to bring some coffee so she could take her pills. Resident #18 was asked why she didn't take the pills when they were initially brought in, and the resident stated that she was eating breakfast at the time and didn't like taking her medications with breakfast. On 3/16/2021 at 10:50 AM, licensed practical nurse (LPN #3), who was sitting at the nurse's station, was asked if she had left the medications in Resident #18's room. LPN #3 stated that she did and that she had been told it was okay to do in a long term care setting. On 3/16/2021 at 2:15 PM, a review of Resident #18's clinical record was performed. Resident #18 did not have an assessment to self-administer medications. Resident #18's physician's order set (POS) lacked an order to self-administer medications. On 3/17/2021 at 2:45 PM, a review of facility policy, "General Dose Preparation and Medication Administration" (Revised 5/1/2010) documented:	F 658	educated on the self medication administration policy. Medication pass observations will be observed weekly x 4 weeks with any issues corrected immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021	

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ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

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F 658	Continued From page 12 "During medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following: (sic) Observe the resident's consumption of the medication(s)." On 3/17/2021 at 4:00 PM, the administrator and DON were informed of the above findings and the DON stated, "that's nursing 101 and the nurse has already been in-serviced." No other information was presented prior to exit conference on 3/19/21.	F 658		
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 observation, staff interview, and clinical record review, the facility failed to follow physician orders for protective arm sleeves for one of 22 resident's, Resident #8. The Findings Include: Resident #8 was admitted to the facility on 5/1/20. Diagnoses for Resident #8 included: Cellulitis, diabetes, neuropathy and dementia. The most current MDS (minimum data set) was a quarterly	F 684	F684 1. Protective arm sleeves were placed on resident #8. 2. Current residents with orders for protective arm sleeves will be reviewed to ensure they are available and placed as ordered. Any issues will be corrected immediately at the time of observation. 3. Licensed nursing staff will be educated on the need to apply protective arm sleeves as ordered. Licensed nursing	4/27/21

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F 684	Continued From page 13 assessment with an ARD (assessment reference date) of 12/5/20. Resident #8 was assessed with a cognitive score of 5 indicating severe cognitive impairment. On 03/16/21, Resident #8's medical record was reviewed. An active physician's order, originally dated 11/24/20 documented "Tubi grip [arm protectors] to both forearms Q [every] shift for protection [...]" Resident #8's current care plan included a care plan regarding skin impairment. An intervention dated 11/25/20 read "Tubi Grip sleeves to BUE [bilateral upper extremity]." On 03/16/21 at 10:58 AM, Resident #8 was interviewed. During the interview Resident #8's arms were observed with dime sized bruising and without protective arms sleeves in place. On 03/16/21 at 03:42 PM, Resident #8 was observed again without tubi grips to arms. Registered Nurse (RN #2) also observed Resident #8 without arm protectors, then went to Resident #8's room to look for the arm protectors but could not find them. RN #2 explained that she was just starting her shift and that the arm protectors were supposed to be on because Resident #8 picks at his arms and bruises easily and she would go get new ones and place them on Resident #8. On 3/17/21 at 3:45 PM, the above finding was presented to the director of nursing and administrator. No other information was presented prior to exit conference on 3/19/21.	F 684	staff will be responsible for applying protective arm sleeves as ordered. Residents with orders for protective arm sleeves will be reviewed 3x weekly x 4 weeks to ensure orders are being followed with corrections made immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021	

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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 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 observation, staff interview, facility document review and clinical record review, the facility staff failed to assess and provide care/treatment to pressure ulcers for one of 22 residents in the survey sample, Resident #142. Resident #142, assessed with pressure ulcers upon admission to the facility, had no assessment and interventions implemented for care/treatment of the wounds. The findings include: Resident #142 was admitted to the facility on 3/12/21 with diagnoses that included pancreatitis, end stage renal disease with hemodialysis, depression, atherosclerotic heart disease, bullous pemphigoid, anxiety, diabetes, hypertension, atrial flutter, anemia and hip fracture. The admission assessment dated 3/12/21 assessed Resident #142 as alert, oriented to person with confusion and short-term memory problems.	F 686	F686 1. Resident #142 no longer resides in facility. 2. Current residents who admitted in the last 7 days will be reviewed to ensure pressure ulcers have been assessed and treatments initiated. 3. Licensed nursing staff will be educated on importance of accurate skin assessments and initiation of treatments for pressure ulcers on admission. Nursing leadership will review 10% of new admissions weekly x 4 weeks to ensure accuracy. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021.	4/27/21

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F 686	Continued From page 15	F 686		

This assessment listed the resident as incontinent of bowel/bladder and as requiring physical assistance of two people for bed mobility and totally dependent upon staff for transfers.

Resident #142's clinical record documented a hospital discharge summary dated 3/12/21. The hospital discharge instructions documented, "...has stage 2 ulcers sacrum/buttocks, dressing change daily - cleanse w/ [with] saline, cover w/ Allevyn [dressing]..."

Resident #142's clinical record documented an admission skin assessment dated 3/12/21. This assessment documented the resident was admitted with a pressure ulcer on the right buttock and a pressure ulcer on the left buttock. The assessment documented that pink tissue was present in the wounds with no drainage, tunneling or undermining. There was no further description of the wounds, no staging of the ulcers, no measurements of wounds and no specific location of the wounds other than right and left buttock.

Resident #142's clinical record as of 3/16/21 documented no further assessment of the pressure ulcers and no physician ordered care/treatment of the wounds. There was a physician's order dated 3/12/21 for silver sulfadiazine cream 1% with instructions stating, "Apply to affected area topically every 12 hours as needed for Wound." This as needed order failed to specify for which "wound" the silver sulfadiazine cream was prescribed and treatment records documented no application of this cream as of 3/16/21.

Nursing notes dated 3/13/21 at 5:10 a.m., 3/14/21

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F 686	Continued From page 16	F 686		

at 6:39 a.m., 3/15/21 at 3:11 a.m. and 3/17/21 at 4:02 a.m., documented a dressing to the resident's buttock was dry and intact but made no mention as to type of dressing or when the dressings were applied or changed. There were no physician orders for dressing changes or any treatment to the pressure ulcers. Treatment records from 3/12/21 through 3/16/21 included no entries of any pressure ulcer treatments or dressing applications. The physician and/or physician's assistant assessed Resident #142 on 3/15/21 and 3/16/21 and made no mention of pressure ulcers or a treatment plan for the wounds.

On 3/17/21 at 10:17 a.m., the licensed practical nurse (LPN #1) caring for Resident #142 was interviewed about the pressure ulcers. LPN #1 reviewed the clinical record and stated he found no orders regarding treatment of pressure ulcers. LPN #1 stated it was reported to him at shift change the resident had stage 2 pressure ulcers on his buttocks but he was not sure of how many or exactly where the wounds were located. LPN #1 stated he did not know what treatments or dressing changes were required for the ulcers. LPN #1 stated there was an as needed order for silver sulfadiazine cream to be applied to a "wound" but he did not know for which wound this was prescribed as the resident had other skin impairments including scabs, blisters and a skin tear.

On 3/17/21 at 2:15 p.m., with the resident's permission and accompanied by LPN #1, Resident #142's skin was assessed. The resident had an open wound on the upper right buttock adjacent to the sacral area. This wound was irregular shaped, approximately the size of a

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nickel with no visible depth. Below this wound was a second, smaller ulcer on the right buttock also irregular in shape. The wound beds were red with pink surrounding tissue. LPN #1 measured the open areas with the upper wound measuring 2.0 x 1.1 (length by width in centimeters) and the second wound measuring 0.8 cm x 0.6 cm with no measurable depth. The left buttock had scarred skin with no open wounds. The resident had on an incontinence brief with neither right buttock wound covered with a bandage or dressing. There were adhesive, foam dressings in place on the bottom of both heels. The dressings had no date or initials indicating when or who applied the dressings. LPN #1 removed the heel dressings. The bottom of both heels had areas of irregular shaped black, dry, flaking skin with tan colored flaking skin in the center of each area. LPN #1 stated at the time of this observation he did not know who applied the dressings or where they came from, as there were no orders for dressings for the resident's heels.

Resident #142's baseline care plan dated 3/15/21 included no problems, goals and/or interventions regarding pressure ulcers or skin care.

On 3/17/21 at 2:54 p.m., the director of nursing (DON) was interviewed about the lack of assessment and treatment for Resident #142's pressure ulcers. The DON stated the charge nurse completed Resident #142's admission assessment on 3/12/21. The DON stated the admitting nurse was supposed to consult with the physician and obtain any needed orders for care/treatments based upon the assessment. The DON stated upon admission, care/treatment of skin issues and medications were a priority.

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F 686	Continued From page 18	F 686		

The DON stated a LPN completed the admission assessment but a registered nurse (RN) supervisor was available staging of pressure ulcers. The DON stated the admitting LPN should have notified the RN about the pressure ulcers for staging and assessment.

On 3/18/21 at 8:15 a.m., the DON stated she did not know who applied the heel dressings observed on 3/17/21 or when they were applied. The DON stated again the nurse that admitted the resident should have called the doctor and obtained orders for care of the ulcers at the time of admission.

The facility's policy titled Pressure Ulcer Monitoring & Documentation (effective 11/1/19) stated, "All pressure ulcers will be monitored...A licensed nurse will assess patient for the presence of pressure ulcers/injuries; if a pressure ulcer/injury is present, the nurse will evaluate for complications...The Skin Wound Evaluation will be completed weekly by a licensed nurse for any patient with pressure ulcer/injuries...There will be a Wound Evaluation for each site."

The National Pressure Injury Advisory Board defines a stage 2 pressure injury as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible...These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel..." (1)

These findings were reviewed with the administrator and director of nursing during a

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F 686	Continued From page 19 meeting on 3/17/21 at 3:45 p.m. and on 3/18/21 at 8:45 a.m. (1) NPIAP Pressure Injury Stages. National Pressure Injury Advisory Panel. 3/19/21. https://npiap.com/	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690		4/27/21

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F 690	Continued From page 20 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure infection control practices were followed for a Foley catheter for one of 22 residents in the survey sample, Resident #54. Findings include: Resident #54 was admitted to the facility on 01/05/21. Diagnoses for Resident #54 included, but were not limited to: pneumonia, sleep apnea, altered mental status, anxiety disorder, depression, thyroid disorder, high blood pressure, history of stroke, seizure disorder and urinary retention. The most current full MDS (minimum data set) was a significant change assessment dated 02/02/21. The resident was assessed as having short and long term memory impairment with severe impairment in daily decision making skills. The resident was assessed to require extensive to total assistance for all ADLs (activities of daily living). The resident was assessed as having a catheter on this MDS. On 03/16/21 at 12:20 PM, Resident #54 was sitting in a geri chair recliner in the dining room. The resident was pulled up to the table with his meal in front of him. The resident's Foley catheter bag did not have a privacy bag and the	F 690	F690 1. Resident #54 was provided with a privacy bag for foley catheter and tubing removed from the floor. 2. Current residents with foley catheters will be reviewed to ensure privacy bag is in place and tubing is off the floor. Corrections will be made immediately at the time of identification. 3. Current nursing staff will be educated on privacy and infection control practices related to foley catheters. Infection preventionist or designee will visualize residents with foley catheters 3x weekly x 4 weeks to ensure infection control practices for a foley catheter are being followed. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021	

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F 690	Continued From page 21	F 690		

drainage valve tube was not in it's holder (extending downward) and was touching the floor.

On 03/16/21 at 12:30 PM, CNA (certified nursing assistant) #8 came over to the table to assist the Resident #54 with his meal. CNA #8 assisted the resident for approximately 5 minutes, but did not address the resident's catheter being on the floor.

For the next 15 minutes, CNA #8 and CNA #9 were both in and out of the dining room area assisting and setting up trays, and passing trays. Neither CNA addressed the resident's catheter drainage tubing being on the floor.

On 03/16/21 at 12:44 PM, CNA #8 was back in the dining room assisting resident's. Resident #54's Foley drainage tubing was still touching the floor.

On 03/16/21 at 1:03 PM, CNA #9 was interviewed regarding Resident #54. CNA #9 stated that Resident #54 was being taken care of by CNA #8. CNA #9 was asked if something needed to be fixed and/or addressed do they (the CNAs) help each other out. CNA #9 stated that they do help each other if something needs to be addressed and the other isn't available. CNA #9 stated that CNA #8 was in a patient room at this time. CNA #9 was made aware of Resident #54's Foley catheter drainage tube touching the floor. CNA #9 stated, "It isn't supposed to be touching the floor." The CNA then turned and walked away. Approximately 3 to 4 minutes later the CNA #9 came back with gloved hands and picked up catheter off floor.

On 03/17/21 at 8:09 AM, Resident #54 was observed in bed. The resident's Foley catheter

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F 690	Continued From page 22	F 690		

bag was hanging on the side of bed rail; the valve clamp tubing was not in it's holder, it was extending downward toward the floor (as observed on 03//16/21), but was not touching the floor. There was no privacy bag on the resident's catheter bag.

On 03/17/21 at approximately 4:15 PM, the DON (director of nursing), administrator and corporate nurse were made aware of the above observations. A policy was requested on the care and treatment of catheters.

Resident #54's CCP (comprehensive care plan) was reviewed and documented, "...The resident has an indwelling catheter...The resident will show no s/sx (signs and symptoms) of urinary infection through review date...The resident will be/remain free from catheter-related trauma through review date...catheter: Position catheter bag and tubing below the level of the bladder...monitor for s/sx of discomfort on urination and frequency...Monitor/document for pain/discomfort due to catheter...Monitor/record/report to MD (medical doctor) any s/sx UTI (urinary tract infection)."

Resident #54's orders were then reviewed and documented, "...Change Foley Cath Q [every] 30 days and PRN [as needed] for clinical indications such as infection, obstruction, or when the closed system is compromised...every 24 hours as needed for urinary retention...Change Foley Cath Q 30 days and PRN for clinical indications such as infection, obstruction, or when the closed system is compromised...every night shift every 1 month(s) starting on the 6th..."

On 03/18/21 at 9:00 AM, the administrator, DON

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F 690	Continued From page 23 and corporate nurse were again made aware of the above observations and were again asked, for a policy on infection control related to Foley catheters and care. The policy was presented titled, "Infection Prevention & Control Policies & Procedures...Indwelling urinary Foley catheter & drain bag changes..." The policy documented, "...protect the closed system...prevent ascending urinary tract infection...frequency of the system change...maintain the integrity of the closed system at all times. Properly secure catheter tubing..." No further information and/or documentation was presented prior to the exit conference on 03/19/21 to evidence that Resident #54's Foley catheter was maintained and/or cared for in a manner to prevention infection of an indwelling catheter.	F 690		
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 observation, staff interview and clinical record review, the facility staff failed to monitor a dialysis access port for one of 22 residents in the survey sample. For four days after admission, facility staff failed to assess Resident #142's dialysis access port for complications.	F 698	F698 1. Resident #142 no longer resides in facility. 2. Current residents with dialysis access ports will be reviewed to ensure physician orders are in place at the time of	4/27/21

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F 698	Continued From page 24 The findings include: Resident #142 was admitted to the facility on 3/12/21 with diagnoses that included pancreatitis, end stage renal disease with hemodialysis, depression, atherosclerotic heart disease, bullous pemphigoid, anxiety, diabetes, hypertension, atrial flutter, anemia and hip fracture. The admission assessment dated 3/12/21 assessed Resident #142 as alert, oriented to person with confusion and short-term memory problems. This assessment listed the resident as incontinent of bowel/bladder and as requiring physical assistance of two people for bed mobility and totally dependent upon staff for transfers. Resident #142's clinical record documented an admission assessment dated 3/12/21 listing the resident had a "catheter port" on his chest. Resident #142's clinical record documented a physician's order dated 3/12/21 for hemodialysis each Monday, Wednesday and Friday. The resident's baseline care plan (dated 3/15/21) documented the resident had hemodialysis three times per week. Included in interventions to prevent complications was, "Monitor and observe port use for dialysis. Notify MD [physician] of any pain at site or any signs and symptoms of Infection..." Resident #142's clinical record including treatment records documented no assessment and or monitoring of the dialysis access port. Nursing notes from 3/12/21 through 3/16/21 made no mention of the access port or the appearance of the port dressing. Resident #142's clinical record documented no physician orders for monitoring of the dialysis access site.	F 698	admission for immediate care and currently active. Corrections will be made as indicated. 3. Licensed nursing staff will be educated on the need for physician orders for monitoring of dialysis access ports at the time of admission. Licensed nursing staff will ensure orders for monitoring of dialysis access ports are in place at the time of admission. Nursing leadership will review 10% of new admissions weekly x 4 weeks to ensure accuracy of orders. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021.	

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F 698	Continued From page 25	F 698		

On 3/17/21 at 9:55 a.m., the licensed practical nurse (LPN #1) caring for Resident #142 was interviewed about the resident's dialysis port. LPN #1 stated he was did not know the location of the resident's port. LPN #1 reviewed the resident's clinical record and stated he found no physician orders regarding monitoring of the dialysis catheter. LPN #1 stated a skin assessment dated 3/12/21 documented a "catheter port" on the resident's chest. Concerning any orders for monitoring of the site, LPN #1 stated, "I don't see any orders period." LPN #1 stated dialysis access ports were usually monitored for bleeding and to make sure the dressing remained intact. LPN #1 stated there were no orders entered regarding the port and therefore no entry on the treatment record for documenting checks of the site.

On 3/17/21 at 2:15 p.m., with the resident's permission and accompanied by LPN #1, Resident #142's skin was assessed. The resident had a dialysis access port on his right upper chest. The dressing was dated 3/17/21 and was clean, dry and intact with no signs of complications.

On 3/18/21 at 8:30 a.m., the director of nursing (DON) was interviewed about lack of assessment/monitoring of Resident #142's dialysis port. The DON stated dialysis care was listed on the baseline care plan but no orders were entered to monitor and check the access site each shift. The DON stated dialysis staff changed the dressing but facility nurses were supposed to check the site each shift for bleeding, dressing condition and signs of any complications.

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F 698	Continued From page 26 This finding was reviewed with the administrator and director of nursing during a meeting on 3/18/21 at 8:45 a.m.	F 698		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and	F 758		4/27/21

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F 758	Continued From page 27 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility failed to ensure one of 22 residents in the survey sample was free of unnecessary psychotropic medications. Resident #56 had physician orders for as needed (PRN) psychotropic medications that extended for more than 14 days without a stop date. The findings include: Resident #56 was originally admitted to the facility on 10/04/2018 and readmitted on 04/11/2019 with diagnoses that included unspecified dementia without behavioral disturbance, hyperlipidemia, colostomy, muscle weakness, hypertension, hypothyroidism, and encounter for palliative care - hospice. The most recent minimum data set (MDS) dated 02/13/2021 which was a quarterly assessment, assessed Resident #56 as severely cognitive impaired for daily decision making with a score of 4 out of 15.	F 758	F758 1. The PRN psychotropic medications for resident #56 have been discontinued. 2. Current residents receiving PRN psychotropic medication will be reviewed to ensure stop date is present. Pharmacist will review current residents receiving PRN psychotropic medications during monthly reviews and will recommend stop dates as indicated. Physician will be notified for stop date request. 3. Physician will be educated on the requirement to provide a stop date on any PRN psychotropic medication. If the physician deems it necessary to continue the PRN for greater than 14 days he will document the rationale and the duration of the PRN order in the medical record. Nursing leadership will review current residents receiving PRN psychotropic medications weekly x 4 weeks to ensure stop dates are in place. Corrections will be	

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F 758	Continued From page 28 On 03/17/2021 Resident #56's clinical record was reviewed. Observed on the physician order sheet was the following: "Ativan Tablet 0.5 MG (milligrams) (LORazepam) Give 1 tablet by mouth every 6 hours as needed for anxiety/air hunger/end of life hospice patient. Order Status: Active. Order Date: 09/02/2020. Start Date: 09/02/2020." "traZODone HCl Tablet 50 mg (milligrams). Give 0.5 tablet by mouth every 8 hours as needed for anxiety/agitation. Order Status: Active. Order Date: 02/21/2020. Start Date: 02/21/2020." There was no documented stop date for the PRN (as needed) Ativan or PRN Trazodone orders. A review of the medication administration record (MAR) for the period of August 2020 through March 2021 documented Resident #56 received the doses of the PRN Ativan on: 08/5/2020, 12/13/2020, 12/17/2020, 01/26/2021, and 02/19/2021. The MAR documented Resident #56 received the doses of the PRN Trazodone on 08/05/2020 and 12/14/2020. A review of the pharmacy consultation reports for the period of September 2020 through March 2021 documented the following recommendations for the PRN Ativan and PRN Trazodone orders: " ....September 22, 2020 through September 24, 2020. [Resident #56] has a PRN order for an anxiolytic, without a stop dated: lorazepam and trazodone. **hospice**. Recommendation: If the medication cannot be discontinued at this time, please document:	F 758	made as indicated. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021.	

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1. the indication for use.
2. the intended duration for therapy (end date) ** perhaps 6 months in this hospice resident**.
3. the rationale for the extended time period.
Rationale for Recommendations: CMS requires that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnoses specific condition being treated, the rationale for the extended tie period, and the duration for the PRN order. References: 42 CFR 483, Subpart B - Requirements for Long Term Care Facilities.

Physician's Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reason below: Rationale: still needs."

The form was signed by [Medical Director], no date was included. The DON who signed the form on 10/2/20 was no longer employed by the facility.

" ....January 23, 2021 through January 26, 2021. [Resident #56] has a PRN order for an anxiolytic, with a stop date: lorazepam and trazodone **hospice**.
Recommendation: If the medication cannot be discontinued at this time, please document:
1. the indication for use.
2. the intended duration of therapy (end date) ** perhaps 6 months in this hospice resident".
3. the rationale for the extended time period.
Rationale for Recommendation: CMS requires that PRN orders for non-antipsychotic psychotropic drugs be limited to 14 days unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration of the PRN order. References: 42 CFR 483, Subpart B -

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F 758	Continued From page 30 Requirements for Long Term Care Facilities. Physician's Response: I decline the recommendation(s) above and do not wish to implement any changes due to the reasons below. Rationale: still needs." The form was signed by the [Medical Director], no date was included. The DON who signed the form on 03/05/2021 was no longer employed by the facility. On 03/17/2021 at 3:00 p.m. the administrator, DON (director of nursing), and corporate staff were informed of the above findings during a meeting. The DON was asked about the expectations for the rationale and/or end date of the PRN antipsychotic medications. The DON stated she could not speak directly for the medical director, however she would have a discussion with him because the resident was improving and was not receiving the medications. No further information was provided prior to exit.	F 758		
F 761 SS=E	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	F 761		4/27/21

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F 761	Continued From page 31 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 expired medications were not readily available for distribution on the 200 unit and 300 unit, and failed to label an open vial of insulin on the 400 unit. The findings include: 1. On 03/17/2021 at 7:37 a.m. medication storage observations were conducted on the 300 all RN #1 (registered nurse). Observed on the 300 long hall medication cart were the following opened bottle of medications: 1. Rugby Vitamin B-12 1000 mcg (microgram) supplement 100 tablets, open date 9/8/20, expiration date 4/20. 2. Sunmark Loratadine 10 mg (milligram) antihistamine 90 tablets, open date 1/2/20, expiration date 11/20.	F 761	F761 1. Expired over the counter medications were discarded. 2. All medication carts, medication rooms, and central supply storage areas were observed to ensure no expired over the counter medications were available. Corrections were made as necessary. 3. Central supply coordinator will be educated to observe all over the counter medications monthly for expiration dates and discard as indicated. SDC or designee will audit medication carts and medication rooms weekly x 4 weeks to ensure all expired over the counter medications are discarded. 4. Process will be reviewed in QA x 1 quarter. 5. 4-27-2021	

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3. Gericare Theratabs High Potency Multivitamin formula 100 caplets, open date 8/9/20, expiration date 7/20.

4. Gericare Extra Strength Simethicone Gas Relief 125 mg (milligrams) 30 tablets, open date 8/1/20, expiration date 12/20.

On 03/17/2021 at 8:02 a.m., RN #1 was interviewed regarding expiration medication. RN #1 stated, "we are supposed to complete random checks for expired meds, there is probably not enough consistency with the checks if we are finding this many expired meds."

2. On 03/17/2021 at 8:22 a.m., medication storage observations were conducted on the 200 hall with LPN #1 (licensed practical nurse). Observed on the 200 hall medication cart was an open bottle of Gericare Ibuprofen 200 mg (milligram) 100 tablets, open date 1/16/21, expiration date 7/20.

On 03/17/2021 at 8:30 p.m., LPN #1 was interviewed regarding the expired medication. LPN #1 stated, "I am an agency nurse and have been here only about 2 weeks. I would think maybe there is a third shift nurse who routinely checks the cart for expired meds."

On 03/17/2021 at 3:00 p.m. the administrator, DON (director of nursing), and corporate staff were informed of the above findings during a meeting.

No other information was provided to the survey team prior to the exit conference on 03/19/2021.
2. On 3/17/2021 at 8:30 AM, 400 hall medication cart #2 was inspected with licensed practical

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F 761	Continued From page 33 nurse (LPN #2). A Lantus Solostar insulin pen was found with no date to indicate when it was opened. LPN #2, confirmed the insulin pen had been used, and stated "I keep telling them to they need to date these things when they open them." A review of the facility's medication storage policy with a revision date of 01/01/13 documented the following: " ...5. Once any medication or biological package is opened. Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened ....." No other information was presented prior to exit conference on 3/19/21.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		4/27/21

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F 812	Continued From page 34 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility policy review, facility staff failed to store food in a sanitary manner in the main kitchen. Findings included: On 03/16/21 at 10:30 A.M. an initial tour of the main kitchen was conducted along with the dietary manager (other staff, OS #2). The walk in refrigerator was observed. An opened packet of a partial whole ham had no label indicating open or expiration date. A container of cooked egg noodles was open to air (not covered) and without a label. OS #2 was asked about the open container of egg noodles. OS #2 stated a larger pan of egg noodles had fallen and the staff had picked up the egg noodles and placed them into the small container and they should have been thrown away. The reach in refrigerator was then observed. A packet of sausage patties were open without a label indicating an open or expiration date, and a packet of sliced ham was also opened without a label. OS #2 stated that the packages should have labels on them. A "Refrigerator Food Storage Schedule" was attached to the front of the walk in refrigerator and indicated that whole ham could be stored for 7 days, and sliced opened ham could be stored for 5 days.	F 812	F812 1. Corporate dietitian completed sanitation rounds and items with no use by date, expired, or not sealed were discarded. 2. Corporate dietitian educated all current dining staff regarding food storage guidelines. 3. Dietary services manager will complete morning and evening rounds form 5x weekly. Administrator will review rounds form for accuracy 1x per week x 4 weeks. 4. Process will be reviewed in QA x 1 quarter. 5. 4-27-2021	

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F 812	Continued From page 35 Review of the facility's "Dining Services Policies and Procedures" read in part "1. All refrigerated and frozen foods shall be stored in sealed/closed containers no less than six (6) inches off the floor. 2. All refrigerated and frozen food containers will be labeled, indicating the name of the product and use-by-date." On 3/17/21 at 3:30 PM the above information was presented to the director of nursing and the administrator. No other information was presented prior to exit conference on 3/19/21.	F 812		
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	F 842		4/27/21

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F 842	Continued From page 36 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical 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	F 842		

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	495420	A. BUILDING _____ B. WING _____	C 03/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 37 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to maintain a complete and accurate clinical record for one of 22 residents, Resident #188. An "After Visit Summary" dated 11/19/2020 was not completely scanned into the electronic record. Page one of the summary was identified on the bottom of the page as Page 1 of 6. The remaining five pages were not in the clinical record. Findings were: Resident #188 was admitted to the facility on 11/06/2020 following an approximate two month stay at a local hospital. Her diagnoses included, but were not limited to: Necrotizing faciitis with GBS (Group B Streptococcus), Cardiomyopathy with ejection fraction of 18% with ICD (implantable cardioverter defibrillator) in place and stents, diabetes mellitus, hypertension, Foley catheter (wound protection), loop colostomy (wound protection), morbid obesity and moderate protein calorie malnutrition. The admission MDS (minimum data set) with an ARD (assessment reference date) of 11/12/2020, assessed Resident #188 as cognitively intact with a summary score of "15". Review of the medical record was conducted from 03/17/2021 beginning at approximately 7:30 a.m. through 03/19/2021.	F 842	F842 1. Resident #188 no longer resides in the center 2. Current residents medical records will be reviewed by medical records coordinator to ensure no pages are missing from after visit summaries. Corrections will be made at the time of identification. 3. Medical records coordinator will be educated to ensure all documents are scanned into the medical record in their entirety. Medical records coordinator will provide a copy of all scanned documents to administrator weekly x 4 weeks to check for completion. Corrections will be made at the time of identification. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021	

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F 842	Continued From page 38	F 842		

Resident #188 was seen by her plastic surgeon on 11/19/2020. A consultation report from that visit was observed and contained the following: "Findings: Unacceptable care; Patient has fluid overloading Diagnosis: pelvis and left thigh wound [secondary to] Fournier's [gangrene] Recommendations: Please see typed note."

The typed note was located in the miscellaneous section of the electronic record. The first page of the note was identified as page 1 of 6. The other five pages were not in the electronic record. The DON (director of nursing) was interviewed at approximately 9:15 a.m. and the remaining pages of the physician note were requested. She stated that she would see what she could find.

At approximately 12:00 p.m., the DON reported that the remaining five pages were not at the facility. She stated, "After something is scanned in, it is shredded. She was asked to contact the plastic surgeon's office to see if they could send the facility another copy of the note.

At approximately 2:10 p.m., the DON and nurse consultant reported that the physician's office had ben contacted regarding the five missing pages of the office visit note. Because the resident was deceased the notes could no longer be accessed. They had been directed to contact medical records at the hospital, which they had done but per medical records at the hospital, they did not have access to after visit summaries from the doctor's office. The DON stated, "We don't even know if we got all the pages or not initially." She was asked if medical records should have questioned where the remaining pages were since the first page is identified as one of six, if all

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F 842	Continued From page 39 six had not been received. She stated, "Yes, they should have." No further information was obtained prior to the exit conference on 03/19/2021.	F 842		
F 880 SS=E	Complaint deficiency Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		4/27/21

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F 880	Continued From page 40 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to follow	F 880	F880 1. Residents in unit 4 dining room were	

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F 880	Continued From page 41 infection prevention control practices during communal dining on one of four units, unit 4. The findings include: On 3/16/2021 at 12:15 PM, 14 residents were observed seated in the 400 hall dining room during the lunch time meal. All residents were seated either across from each other or adjacent to each and were approximately less than six feet apart. Additionally, some dining room tables were positioned such that the resident's dining chair/wheelchair backs were nearly touching the backs of the chairs to the tables behind them. On 3/16/2021 at 12:35 PM, certified nursing assistant (CNA #9), who assisted in the 400 hall dining room during the observation, was interviewed regarding social distancing requirements for communal dining. CNA #9 stated that since everyone had gotten the second COVID vaccine, she was told they could start bringing the resident's into the dining room, with 2 at a table, and that although the resident's that were sitting adjacent to each other were not roommates, they had requested to be seated next to each other. When asked about seating the resident's six feet apart, CNA #9 stated, "I'm just a CNA on the floor and have to do what they tell me to do." On 3/17/2021 at 1:30 PM, review of the facility's policy "Albemarle Health & Rehabilitation Center COVID-19 Plan" (no date)documented: "Level 3 COVID-19 Status: Communal Dining; Maintain social distancing with no more than 4 patients at a table and spaced 6 ft [feet] apart (tables)." On 3/18/2021 at 9:00 AM, the DON was	F 880	placed 6 feet apart. 2. Tape markers were placed on the floor in all dining rooms to indicate a 6 foot separation between each table. 3. All current staff will be educated that the tape marker indicates a 6 foot separation and the need to maintain a 6 foot distance between all residents in the dining room. 4. Process will be reviewed in QA committee x 1 quarter. 5. 4-27-2021	

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F 880	Continued From page 42	F 880		

interviewed regarding the follow-up to the dining room tables and stated the maintenance director (OS #5) measured the tables at 3 and ½ feet wide on all sides. The DON also stated "we are working on fixing the situation now."

CDC (Centers for Disease Control and Prevention) guidance dated March 13, 2021, "Healthcare personnel at long-term care facilities should follow the recommended infection prevention and control practices described in the Preparing for COVID-19 in Nursing Homes and the Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. These recommendations, which emphasize close monitoring of residents of long-term care facilities for symptoms of COVID-19, universal source control, physical distancing (when possible), hand hygiene, and optimizing engineering controls, are intended to protect healthcare personnel and residents from exposures to SARS-CoV-2...Because information is currently lacking on vaccine effectiveness in the general population; the resultant reduction in disease, severity, or transmission; or the duration of protection, residents and healthcare personnel should continue to follow all current infection prevention and control recommendations to protect themselves and others from SARS-CoV-2 infection, regardless of their vaccination status." (1)

No other information was presented prior to exit conference on 3/19/21.

(1) CDC (Centers for Disease Control and Prevention), March 13, 2021, Post Vaccine

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F 880	Continued From page 43 Considerations for Residents, accessed March 19, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/post-vaccine-considerations-residents.html>	F 880		