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	495299	A. BUILDING _____ B. WING _____	C 03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/16/21 through 3/18/21. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 03/16/2021 through 03/18/2021. One complaint (VA00050420- unsubstantiated with no deficiencies), was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 180 bed facility was 118 at the time of survey. The survey sample consisted of 52 current resident record reviews and four closed records.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/08/2021

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right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review it was determined facility staff failed to ensure confidentiality and privacy of medical information for one of 52 residents in the survey sample, Resident #50. A facility staff member and a hospice nurse were heard and observed discussing Resident #50's medical information in the hallway, with Resident #78 present in the hallway.

The findings include:

On 3/17/2021 at approximately 10:00 a.m., observation on the hallway of the facility C unit revealed RN (registered nurse) #2 and the visiting hospice nurse. The visiting hospice nurse was heard asking RN #2 how Resident #50 was

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doing. RN #2 proceeded to discuss Resident #50's condition including pain management with the visiting hospice nurse for approximately two minutes. Resident #78 was observed in their electric wheelchair stopped in the hallway approximately four feet away.

Resident #78 was admitted to the facility with diagnoses that included but were not limited to diabetes (1) and cellulitis (2). Resident #78's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 02/13/2021, coded Resident #78 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident #78 was coded under section B as having minimal difficulty for hearing.

Resident #50 was admitted to the facility with diagnoses that included but were not limited to malignant neoplasm of left bronchus or lung (3) and major depressive disorder (4). Resident #50's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 01/27/2021, coded Resident #50 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Section O documented Resident #50 receiving hospice services while a resident at the facility.

The physician's orders for Resident #50 documented in part, "1/22/2021 12:43 (12:43 p.m.) Under services of [Name of hospice] as of 1/21/21 r/t (related to) malignant neoplasm of unspecified part of unspecified bronchus or lung."

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The progress notes for Resident #50 documented in part, "3/17/2021 11:19 (11:19 a.m.) Hospice nurse in facility to visit patient, hospice nurse stated res (resident) was requesting for a Norco (pain medication) due to hip pain. Res denies trauma to hip, AROM (active range of motion) is positive, pain is chronic per patient. Medication given to res as ordered..."

The comprehensive care plan for Resident #50 documented in part, "Patient is on Hospice care related to: End of life/care/Diagnosis of Lung Cancer, Date Initiated: 02/01/2021..."

On 3/17/2021 at approximately 10:05 a.m., an interview was conducted with RN #2. RN #2 stated that privacy for residents medical information was maintained by talking inside of the office or speaking quietly when there was no one around to overhear. When asked if there was anyone in the hallway during the conversation with the hospice nurse, regarding Resident #50's condition, RN #2 stated, "You were." When asked about Resident #78 also being in the hallway, RN #2 stated that she had forgotten that Resident #78 was sitting in the hallway to overhear the conversation. RN #2 stated that she was discussing Resident #50's information, not Resident #78 and that they should have spoken in their office to promote privacy.

On 3/17/2021 at approximately 5:05 p.m., ASM (administrative staff member) #2, the director of nursing stated that the facility used Lippincott as their standard of practice.

On 3/18/2021 at approximately 9:45 a.m., a request was made to ASM #1, the administrator

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for the facility policy for privacy of medical information.

On 3/18/2021 at approximately 1:55 p.m., ASM #1 provided via email, "Resident Rights." The document "Resident Rights" dated "Effective 1/2017" documented in part, "...The Resident has the right to personal privacy and confidentiality of his or her personal and clinical records..."

"Confidentiality: 1. The patient's privacy is consistent with the Hippocratic Oath and with the law as part of the constitutional right to privacy ..." Lippincott Manual of Nursing Practice, 10th Edition; 2014; p. 15.

On 3/17/21 at approximately 5:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Diabetes mellitus - a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

2. Cellulitis is a common skin infection caused by bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected. This information was obtained from the website: https://medlineplus.gov/ency/article/000855.htm.

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F 583	Continued From page 5 3. Malignant neoplasm: The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm. 4. Major depressive disorder is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.	F 583		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		

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(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for four of 52 residents in the survey sample, Residents #22, #47, #58 and #35.

The findings include:

1. The facility staff failed to implement Resident #22's comprehensive care plan for checking the resident's skin under the resident's elbow splints

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every shift.

Resident #22 was admitted to the facility on 4/27/12. Resident #22's diagnoses included but were not limited to anoxic brain damage (1), contractures (2) of the right elbow, left elbow and right hand, and anxiety disorder. Resident #22's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/1/21 coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #22 as requiring total dependence of two or more staff with bed mobility and transfers.

Review of Resident #22's clinical record revealed a comprehensive care plan dated 5/7/12 that documented, "I have a physical functioning deficit related to: Self care impairment, Mobility impairment, involuntary body movements to her head and arms, ROM (range of motion) limitations, dependence on staff for ADLs (activities of daily living)- anoxic brain injury; position elbow splints to both arms per resident's tolerance at bedtime remove for am care, and check skin q (every) shift..."

A physician's order dated 12/6/20 documented, "Bilateral elbow splints; position at bedtime- per resident's tolerance. Remove for hygiene every evening shift." There was no physician's order to check the resident's skin every shift.

Further review of Resident #22's clinical record (including December 2020 nurses' notes, December 2020 ADL records, and the December 2020 TAR (treatment administration record) failed to reveal evidence that the skin under Resident #22's splints was checked every shift. The December 2020 TAR only evidenced the splints

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was removed every evening shift.

On 3/17/21 at 3:56 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the purpose of the care plan is to document things that have happened and also document interventions that have been put in place. LPN #4 stated nurses can reference residents' care plans any time. When shown Resident #22's above referenced care plan, LPN #4 stated nurses should sign off that they are checking the skin under the resident's splints every shift.

On 3/17/21 at 5:19 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy regarding care plans (an excerpt from Lippincott Nursing Procedures 8th Edition) documented, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation, and evaluation."

No further information was presented prior to exit.

References:

(1) "Anoxic brain damage is harm to the brain due to a lack of oxygen." This information was obtained from the website: https://www.winchesterhospital.org/health-library/article?id=96472

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(2) "A contracture is a fixed tightening of muscle, tendons, ligaments, or skin. It prevents normal movement of the associated body part." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9218.htm

2. The facility staff failed to implement Resident # 47's comprehensive care plan for physician ordered oxygen.

Resident # 47 was admitted to the facility with diagnoses that include but not limited to: chronic obstructive pulmonary disease (COPD) [1]. Resident # 47's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/22/2021, coded Resident # 47 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 47 as receiving "Oxygen Therapy" while a resident in the facility.

On 03/16/21 at approximately 11:59 a.m., Resident #47 was observed sitting in their wheelchair receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

On 03/16/21 at approximately 3:11 p.m., a second observation by another surveyor revealed Resident sitting #47 receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen

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flow rate of two and a half liters per minute.

On 03/17/21 at approximately 9:00 a.m., an observation revealed Resident #47 sitting in their wheelchair receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

The physician's order dated 12/09/2019 for Resident # 47 documented, "O2 [oxygen] @ [at] 3L [three liters] via [by] NC [nasal cannula] [2] continuously r/t [related to] COPD.

The comprehensive care plan for Resident # 47 dated 09/11/2018 documented in part, "Focus Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease. Date Initiated: 09/11/2018. Under "Intervention" it documented in part, "Administer oxygen as needed per Physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. Date Initiated: 09/11/2018."

The eMAR [electronic medication administration record] for Resident # 47 dated March 2021 documented the above physician's order for oxygen. Further review of the eMAR documented that Resident # 47 received oxygen at three liters per minute on 03/16/2012 on the shifts of 7:00 a.m. 3:00 p.m., 3:00 p.m. to 11:00 p.m. and on 03/17/2021 on the 7:00 a.m. 3:00 p.m. shift.

On 03/17 2021 at approximately 1:32 p.m., an interview was conducted with RN [registered nurse] # 2, acting unit manager regarding the purpose of a resident's comprehensive care plan. RN # 2 stated that it [comprehensive care plan]

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was a guide to take care of the resident. After entering Resident #47's room and reading the oxygen flow meter on Resident #47's oxygen, RN # 2 stated the oxygen flow rate was set at two and a half liters per minute. When asked what the correct oxygen flow rate for Resident # 47 should be, RN # 2 then reviewed the physician's orders for Resident # 47 and stated that it should be three liters per minute. After reviewing the comprehensive care plan for Resident # 47 dated 09/11/2018 RN # 2 was asked if the comprehensive care plan was being implemented correctly. RN # 2 stated no.

On 03/17/2021 at approximately 5:05 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

[2] Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/nasal+cannula.

3. The facility staff failed to develop a comprehensive care plan for Resident # 58's

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physician ordered oxygen.

Resident # 58 was admitted to the facility with diagnoses that include but not limited to: acute respiratory failure [1]. Resident # 58's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/22/2021, coded Resident # 58 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 58 as receiving "Oxygen Therapy" while a resident at the facility.

On 03/16/21 at approximately 12:06 p.m., Resident #58 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

On 03/16/21 at approximately 3:13 p.m., Resident # 58 was observed receiving oxygen via nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

On 03/17/21 at approximately 9:09 a.m., an observation of Resident #58 revealed the resident lying in bed receiving oxygen via a nasal cannula that was connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

The physician's order dated 01/29/2021 for

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Resident # 58 documented, "O2 [oxygen] @ [at] 2L/min [two liters per minute] continuously r/t [related to] SOB [shortness of breath].

The eMAR [electronic medication administration record] for Resident # 58 dated March 2021 documented the above physician's order for oxygen. Further review of the eMAR documented that Resident # 58 received oxygen at two liters per minute on 03/16/2012 on the shifts of 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. and on 03/17/2021 on the 7:00 a.m. to 3:00 p.m. shift.

The comprehensive care plan for Resident # 58 dated 02/01/2021 failed to evidence documentation for the use of oxygen.

On 03/17 2021 at approximately 1:32 p.m., an interview was conducted with RN [registered nurse] # 2, acting unit manager regarding the purpose of a resident's comprehensive care plan. RN # 2 stated that it [comprehensive care plan] was a guide to take care of the resident. After entering Resident #58's room reading the flow meter on Resident # 58's oxygen concentrator, RN # 2 stated the flow rate was two and a half liters per minute. When asked what the correct oxygen flow rate for Resident # 58 should be, RN # 2 then reviewed the physician's orders for Resident # 58 and stated that it should be two liters per minute. After reviewing the comprehensive care plan for Resident # 58 dated 02/01/2021, RN # 2 was asked if there was a care plan to address Resident # 58's use of oxygen. RN # 2 stated no.

On 03/18/2021 at approximately 9:30 a.m., an interview was conducted with RN # 3, MDS

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coordinator regarding Resident # 58's comprehensive care plan dated 02/01/2021. After review the physician's order for Resident # 58's oxygen, RN # 3 was asked to review the comprehensive care plan for the use of oxygen. RN # 3 stated that a care plan for Resident # 58's oxygen was developed on 03/17/2021.

On 03/17/2021 at approximately 5:05 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. When asked what standard of practice the facility nurses follow, ASM # 2 stated that they use Lippincott.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

No further information was provided prior to exit.

References:
[1]When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

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4a. The facility staff failed to implement Resident # 35's comprehensive care plan for physician ordered oxygen.

Resident # 35 was admitted to the facility with diagnoses that include but not limited to: acute pulmonary edema [1].
Resident # 35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/14/2021, coded Resident # 35 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 35 as receiving "Oxygen Therapy" while a resident at the facility.

On 03/16/21 at approximately 11:38 a.m., an observation of Resident #35 revealed the resident in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

On 03/17/21 at approximately 9:01 a.m., an observation of Resident # 35 revealed the resident was in bed receiving oxygen via nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

The physician's order dated 10/19/2020 for Resident # 35 documented, "Increase O2 [oxygen] to 4L four liters] via [by] nasal cannula continuously related to acute pulmonary edema.

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The comprehensive care plan for Resident # 35 dated 06/13/2019 documented in part, "Focus" Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease: I prefer to use the Incentive Spirometer as I need it and to keep it at my bedside. HX [history] abscess sinus, pulm [pulmonary] edema, copd [chronic obstructive pulmonary disease], lymes disease, asthma. Date Initiated: 06/13/2019." Under "Intervention" it documented in part, "Administer oxygen as needed per Physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. Date Initiated: 06/13/2019."

The eMAR [electronic medication administration record] for Resident # 35 dated March 2021 documented the above physician's order for oxygen. Further review of the eMAR documented that Resident # 35 received oxygen at four liters per minute on 03/16/2012 on the shifts of 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. and on 03/17/2021 on the 7:00 a.m. to 3:00 p.m. shift.

On 03/17 2021 at approximately 1:32 p.m., an interview was conducted with RN [registered nurse] # 2, acting unit manager, regarding the purpose of a resident's comprehensive care plan. RN # 2 stated that it [comprehensive care plan] was a guide to take care of the resident. After entering Resident # 35's room and reading the flow meter RN # 2 stated the oxygen flow rate on Resident #35's oxygen concentrator was two and a half liters per minute. When asked what the correct oxygen flow rate for Resident # 35 should be, RN # 2 reviewed the physician's orders for Resident # 35 and stated that it should be four

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liters per minute. After reviewing the comprehensive care plan for Resident # 35 dated 06/13/2019 RN # 2 was asked if the care plan was being implemented correctly. RN # 2 stated no.

On 03/17/2021 at approximately 5:05 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] An abnormal buildup of fluid in the lungs. This buildup of fluid leads to shortness of breath. This information was obtained from the website: https://medlineplus.gov/ency/article/000140.htm.

4b. The facility staff failed to implement Resident # 35's comprehensive care plan for the use of non-pharmacological interventions prior to the administration of as needed pain medication.

Resident # 35 was readmitted to the facility with diagnoses that included but were not limited to: cancer of the vulva [1] and pain.

Resident # 35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/14/2021, coded Resident # 35 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 35 as having frequent pain at a level of 5 [five] on a pain scale of zero to ten, with ten being the worse pain.

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The current physician's order dated 01/09/2020 documented, "Acetaminophen Tablet 325 MG [milligrams]. Give two tablets by mouth every 4 [four] hours as needed for pain. Not to exceed 3000 G [grams] in a 24 hour period."

Resident # 35's eMAR [electronic medication administration record] dated January 2021 documented the above physician's order for acetaminophen. The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Acetaminophen on: 01/23/2021 at 2:11 p.m. with a pain level of eight, 01/24/2021 at 11:51 a.m. with a pain level of six, 01/25/2021 at 10:49 a.m. with a pain level of six, 01/27/2021 at 12:17 p.m. with a pain level of six, 01/28/2021 at 8:55 p.m. with a pain level of three and on 01/31/2021 at 9:05 p.m. with a pain level of two.

Resident # 35's eMAR [electronic medication administration record] dated February 2021 documented the above physician's order for acetaminophen. The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Acetaminophen on: 02/04/2021 at 4:36 p.m. with a pain level of four, 02/10/2021 at 1:39 a.m. with a pain level of three, 02/21/2021 at 8:30 a.m. with a pain level of four and at 12:45 p.m. with a pain level of six, 02/23/2021 at 8:33 a.m. with a pain level of six and on 02/24/2021 at 8:21 a.m. with a pain level of six.

Resident # 35's eMAR [electronic medication administration record] dated March 2021

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documented the above physician's order for acetaminophen. The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Acetaminophen on: 03/01/2021 at 5:27 a.m. with a pain level of six, 03/13/2021 at 7:43 a.m. with a pain level of six and at 4:51 p.m. with a pain level of two, 03/14/2021 at 5:37 p.m. with a pain level of five.

The comprehensive care plan for Resident # 35 dated 05/09/2019 documented in part, "Focus: Needs Pain management and monitoring related to: Cancer. Date Initiated: 11/08/2018." Under "Interventions" it documented in part, "Implement the patient's preferred non-pharmacological pain relief strategies. Date Initiated: 11/08/2018."

On 03/16/21 at approximately 11:38 a.m., an interview was conducted with Resident # 25. When asked if they are provided with non-pharmacological strategies to alleviate their pain before being given pain medication, Resident # 35 stated that the nurse will ask what their pain level is and give them the pain medication.

Review of Resident # 35's progress notes dated 01/01/2021 through 03/17/2021 failed to evidence documentation of non-pharmacological interventions prior to the administration of as needed acetaminophen.

On 03/18/21 at 8:05 a.m., an interview was conducted with RN [registered nurse] # 2, acting unit manager regarding the procedure staff follows when administering as needed pain medication to a resident. RN # 2 stated ask the resident their pain level on a scale one to ten with

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F 656	Continued From page 20 one being minor pain and ten being unbearable, ask where the pain is and offer an intervention before giving the pain medication and if it doesn't work give the pain medication and follow up in about half an hour. When asked where staff document the non-pharmacological interventions offered/attempted prior to administering pain medication, RN # 2 stated that they document them on the progress notes. After reviewing the eMARs dated January, February and March 2021, progress notes for the above dates and the care plan dated 05/09/2019, RN # 2 was asked if the care plan for Resident # 35 was being implemented for the use of non-pharmacological interventions. RN # 2 sated no. On 03/17/2021 at approximately 5:05 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html. [2] A rare type of cancer. It forms in a woman's external genitals, called the vulva. This information was obtained from the website: https://medlineplus.gov/vulvarcancer.html.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		

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F 658	Continued From page 21 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, it was determined the facility staff failed to follow professional standards of practice for documentation of a resident assessment for one of 52 residents in the survey sample, Resident #118. The facility staff failed to document in the clinical record the assessment completed to determine and declare the death of Resident #118 on 3/3/2021. The findings include: Resident #118 was admitted to the facility on 4/1/2020 with a recent readmission on 12/30/2020 with diagnoses that included but were not limited to: high blood pressure, dementia (1), pain, depression and atrial fibrillation. (2) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/1/2021, coded the resident as having both long and short term memory difficulties and was coded as being severely impaired to make daily cognitive decisions. Resident #118 was coded as requiring extensive assistance to being dependent upon one or more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving hospice care.	F 658		

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A nurse's note dated 3/3/2021 at 2:10 p.m. documented, "Resident observed laying (sic) in bed no breath sounds, no rise and fall in chest, no pulse. Adon (assistant director of nursing) in room with resident to call time of death for 2 pm on 3/3/21. (Name of hospice) called and stated nurse coming out to evaluate. Staff in room to clean resident."

There were no further nursing notes in the clinical record.

On 3/18/2021 at 11:07 a.m., an interview was conducted with LPN (licensed practical nurse) #4 regarding the process staff follows when a resident passes away. LPN #4 stated the nurse checks first if the resident is a full code or a DNR (do not resuscitate). IF a DNR, the nurse, if not an RN (registered nurse) calls an RN to come pronounce the resident's death. When asked who documents the death, LPN #4 stated the nurse can write a note but the RN that does the pronouncement is supposed to write a note. When asked if a nurse does any type of assessment, should they write a note, LPN #4 stated, yes, that is nursing practice.

On 3/18/2021 at 11:22 a.m., an interview was conducted with LPN #3, regarding the process staff follows when a resident receiving hospice is found without a pulse or respirations. LPN #3 stated call hospice to make them aware. When asked how the death is declared, LPN #3 stated an RN must declare the death. Usually there is one in the building or the hospice nurse will come to do that. When asked who documents the assessment that declares the death of a resident, LPN #3 stated she wrote a note (for Resident

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118) but the RN who declares the resident should write a note.

On 3/18/2021 at 11:29 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked about the process staff follows when a resident is found with no respirations or heartbeat. ASM #2 stated the nurse needs to check if they are a DNR or full code. If a DNR, it depends if the nurse is an LPN or RN. If an LPN, she must get an RN to pronounce the resident. ASM #2 stated the LPN can write their own note but the nurse who pronounced the resident needs to write a note also. When asked if a nurse does any type of assessment, should they document their assessment, ASM #2 stated that they should always write a note if they have done an assessment. The resident's progress note dated 3/3/2021 at 2.10 p.m. was read to ASM #2. ASM #2 stated there should have been a note from the RN/ADON (assistant director of nursing) that pronounced the resident. ASM #2 stated the ADON had called her to tell me of the resident's death.

The ADON who declared the resident's death was no longer employed by the facility and was unavailable for interview.

The facility provided a policy, "Assessment Techniques" taken from Lippincott Nursing Procedures, 8th edition, that documented, "Document your assessment findings and the technique used to elicit each finding. Indicate who you notified of any abnormal findings and the time of the notification."

ASM #1, the administrator, was made aware of

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F 658	Continued From page 24 these findings on 3/18/2021 at 2:24 p.m. No further information was obtained prior to exit. (1) Dementia is a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Atrial Fibrillation is a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide ADL (activities of daily living) care for one of 52 residents in the survey sample, Resident #75, who was coded as dependant on staff for personal hygiene. The facility staff failed to provide nail care to Resident #75. Resident #75 was observed with long nails and a jagged broken nail on the middle finger of the left hand.	F 677		

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The findings include:

The facility staff failed to provide ADL (activities of daily living) care, specifically nail care for a dependent resident, Resident #75.

Resident #75 was admitted to the facility on 8/15/19 with diagnoses that included but were not limited to: cerebro- vascular accident (hemorrhage or blockage of vessels to the brain leading to lack of oxygen) (1), paraplegia (paralysis of lower limbs with loss of sensory or motor function) (2) and post-traumatic stress disorder (mood disorder occurring after an event in which the person persistently relives the event) (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 2/10/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. The resident was coded as requiring extensive assistance for bed mobility, transfer, locomotion on and off the unit and eating; total dependence for dressing, toilet use, bathing and personal hygiene. Resident #75 was coded as always incontinent for bowel and frequently incontinent for bladder function.

A review of the comprehensive care plan documented in part, The Focus: dated 8/13/20 "I have a physical functioning deficit related to: Self-care impairment. I have right sided weakness and require extensive to total assistance x 1-2 staff with ADLs (activities of daily

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ELIZABETH ADAM CRUMP HEALTH AND REHAB	3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060

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living)." The Interventions: dated 8/13/20 "Assess the need for assistance with toileting, clothing management, personal care, transfer & locomotion. Provide as needed. Nail care as needed."

On 3/16/21 at 12:20 PM, 3/16/21 at 4:00 PM and 3/17/21 at 9:00 AM, observations of Resident #75's nails revealed the nails on both hands were 0.5-0.75 inches long, with the exception of the middle finger of the left hand, which appeared jagged.

On 3/16/21 at 2:20 PM, an interview was conducted with Resident #75. When asked if he had any concerns about his care, Resident #75 showed me his nails and stated, "They don't cut my nails. Some are good and cut them with my bath; others do not care and will not cut them. I cannot cut them. I've had a stroke."

On 3/17/21 at 11:02 AM, an interview was conducted with LPN (licensed practical nurse) #2. When asked who is responsible for nail care, LPN #2 stated, "If they are not diabetic, then the CNA (certified nursing assistant) cuts their nails when they are being bathed. If they are diabetic, we ask the podiatrist to see the resident".

On 3/17/21 at 1:13 PM, CNA #2 was asked to look at Resident #75's nails. When asked the length of his nails, CNA #2 stated, "Oh they need to be cut. I usually cut their nails and clean them when I'm doing their bath". When asked the approximate length of the nails CNA #2 stated, "They are about one half inch to almost 1 inch. I will get the nail clippers and cut them now. It looks like all of them except this one (middle finger left hand) need cutting, and we'll file that

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F 677	Continued From page 27 one nail". CNA #2 asked resident, "If that is okay with you?" Resident #75 stated, "Yes, that would be great. Thank you." CNA #2 was observed obtaining nail clippers. On 3/17/21 at 4:10 PM, observation revealed Resident #75's nails had been trimmed. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were informed of the loose medications, expired medications and biological's on 3/17/21 at 5:05 PM. No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 111. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 432. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 467.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the	F 684		

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facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for one of 52 residents in the survey sample, Resident #77.

The facility staff failed to follow the physician's order for thickened liquids during the medication administration for Resident #77. On 3/17/21 at approximately 9:05 a.m., Resident #77 was administered their medication with regular water.

The findings include:

Resident #77 was admitted to the facility with diagnoses that included but were not limited to dysphagia (1) and dementia (2). Resident #77's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 02/12/2021, coded Resident #77 as scoring a 10 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 10- being moderately impaired for making daily decisions. Section K documented Resident #77 receiving a mechanically altered diet and therapeutic diet.

On 3/17/2021 at approximately 9:05 a.m., an observation was made of LPN (licensed practical nurse) #5 preparing medications for Resident #77. LPN #5 used the electronic medication administration record to prepare the following medication for Resident #77, clopidogrel bisulfate (blood thinner) 75mg (milligram) 1 tablet, iron (supplement) 65mg 1 tablet, hydrochlorothiazide (diuretic) 25mg 1 tablet, memantine hcl (hydrochloride) (cognition-enhancing) 10mg 1 tablet, paroxetine hcl (antidepressant) 20mg 1 tablet, vitamin C (supplement) 500mg 1 tablet,

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norvasc (blood pressure) 2.5mg 1 tablet, and metformin (anti-diabetic) 500mg two tablets. LPN #5 was observed pouring water into a plastic cup approximately 7 ounces in size. LPN #5 was then observed administering the medications to Resident #77 with the water in the cup. Resident #77 drank approximately one ounce of water to swallow the medications. Resident #77 was not observed coughing after swallowing the medications and water. LPN #5 disposed of the remainder of the water and washed their hands. Upon returning to the medication cart and reviewing the electronic medication record, LPN #5 stated that she had made a mistake in giving Resident #77 the plain water. LPN #5 stated that she did not realize that Resident #77 was on thickened liquids until she reviewed the computer and proceeded to show the computer screen which stated that Resident #77 was to receive thickened honey liquids. LPN #5 stated that she was going to alert the physician that Resident #77 had drank the regular water to swallow their medications and did not have any coughing afterwards and she was going to assess and monitor them.

The physician's orders for Resident #77 documented in part, "8/18/2020 08:43 (8:43 a.m.) Diet Type: CCD (consistent carbohydrate diet), Diet Texture: Dysphagia Advanced, Fluid Consistency: Thickened Liquid Honey..." and "3/23/2018 09:24 (9:24 a.m.) May crush medications and administer per food..."

The "Nutrition Data V2.1" dated 2/9/21 for Resident #77 documented in part, "...Conditions impacting oral intake: Swallowing Disorder, Dx (diagnosis) dysphagia; Dehydration Risk Factors: Diuretic Use, Thickened Liquids, Dementia..."

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The progress notes for Resident #77 documented in part, "3/17/2021 15:06 (3:06 p.m.) ...Situation: while administering medication, was given 1 sip of water. Background: A [Age and Sex of Resident #77], full code, with dysphagia and on Honey Thickened fluids. Assessment: Patient tolerated medications well, no noted coughing, no noted swallowing difficulty, no noted SOB (shortness of breath). Response: NP (nurse practitioner) in to see patient, no new orders, continue to monitor..."

The comprehensive care plan for Resident #77 documented in part, "[Resident #77] is at risk for imbalanced nutrition r/t (related to) dx (diagnosis) of dementia, DM2 (diabetes mellitus type two) (3), HTN (hypertension) (4), diuretic treatment, mechanically altered diet, therapeutic diet. Date Initiated: 04/03/2018..."

On 3/17/2021 at approximately 10:05 a.m., an interview was conducted with RN #2. RN #2 stated that the nurses ensured that the right medication, right time, right route, right dosage were given to the correct resident. RN #2 stated that the nurse should be aware of the residents who need thickened liquids during medication administration. RN #2 stated that the thickened liquids were available to staff and residents in the nourishment rooms on each unit. RN #2 stated that she believed the problem was that the nurse had to look on the electronic dashboard to see the diet order for the resident and that it did not show on the electronic medication administration record. RN #2 stated that the nurse would have the information available to them on the census sheet also and the electronic dashboard. RN #2 stated that it would be ideal for this to show on

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the medication administration screen for the nurse to see when preparing medication also.

On 3/17/2021 at approximately 5:05 p.m., ASM (administrative staff member) #2, the director of nursing stated that the facility used Lippincott as their standard of practice.

On 3/18/2021 at approximately 9:45 a.m., a request was made to ASM #1, the administrator for the facility policy for medication administration and thickened liquids.

On 3/18/2021 at approximately 1:55 p.m., ASM #1 provided via email, "Safe Medication Administration Practices, General" from Lippencott Nursing Procedures, Eighth Edition. The document "Safe Medication Administration Practices, General" failed to evidence guidance regarding following physician orders for administration of fluids.

Fundamentals of Nursing, Lippincott Williams & Wilkins, fifth edition, 2007. Page 557, "Nurses are expected to practice in a safe and prudent manner. Each nurse is responsible for being knowledgeable about the medication's actions, indications, contraindications, and any adverse effects. Knowledge of appropriate dosages and dosage schedules, routes and methods of administration, and actions to take if the client has an adverse reaction is also important ....."

On 3/17/21 at approximately 5:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

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F 684	Continued From page 32 References: 1. Dysphagia is a swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html 2. Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 3. Diabetes mellitus is a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 4. Hypertension is High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a 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	F 686		

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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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement professional standards of practice for the prevention of a pressure injury for one of 52 residents in the survey sample, Resident #22.

The facility staff failed to frequently assess the skin under Resident #22's splints. On 12/15/20, the resident developed a pressure injury on the right arm.

The findings include:

Resident #22 was admitted to the facility on 4/27/12. Resident #22's diagnoses included but were not limited to anoxic brain damage (1), contractures (2) of the right elbow, left elbow and right hand, and anxiety disorder. Resident #22's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/1/21 coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #22 as requiring total dependence of two or more staff with bed mobility and transfers. Section M coded the resident as having a stage 2 pressure injury (3).

Review of Resident #22's clinical record revealed a comprehensive care plan dated 5/7/12 that documented, "I have a physical functioning deficit related to: Self care impairment, Mobility impairment, involuntary body movements to her

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head and arms, ROM (range of motion) limitations, dependence on staff for ADLs (activities of daily living)- anoxic brain injury; position elbow splints to both arms per resident's tolerance at bedtime remove for am care, and check skin q (every) shift..."

A physician's order dated 12/6/20 documented, "Bilateral elbow splints; position at bedtime- per resident's tolerance. Remove for hygiene every evening shift." There was no physician's order to check the resident's skin every shift.

Further review of Resident #22's clinical record (including December 2020 nurses' notes, December 2020 ADL records, and the December 2020 TAR (treatment administration record) failed to reveal evidence that the skin under Resident #22's splints was checked every shift. The December 2020 TAR only evidenced the splints were removed every evening shift (including the evening of 12/14/20).

A nurse's note dated 12/15/20 documented, "Situation: open area under right under arm. Background: contracted, wear arm splint. Assessment: aide was providing care for resident when she alerted writer to an open area under residents right arm- open area is 0.6 x (times) 0.5 x 0.1, with a sour odor and purulent drainage. tissue (sic) to area is very thin and fragile with discoloration (bright purplish red in color), area is tender to touch while writer and aide are attempting to maneuver residents (sic) arm to have clear access to open area. Response: NP (nurse practitioner) made aware of event, NOO (new order obtained) to remove splint and orders for treatment..."

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An initial pressure injury record dated 12/15/20 documented a stage 4 (3) pressure injury measuring 0.6 cm (centimeters) in length by 0.5 cm in width by 0.1 cm in depth on Resident #22's right upper arm (note- it was later determined that this pressure injury was inaccurately documented as a stage 4). Further review revealed the pressure injury was evaluated and documented as healed by the wound physician on 1/6/21.

On 3/16/21 at 3:37 p.m. Resident #22 was observed in a specialized wheelchair and no pressure injury was observed under the residents right arm.

The nurse who cared for Resident #22 during the evening shift on 12/14/20 was not available for interview. The CNA (certified nursing assistant) and nurse who cared for Resident #22 during the night shift of 12/14/20 into 12/15/20 were not available for interview.

On 3/17/21 at 1:25 p.m., an interview was conducted with OSM (other staff member) #3, the director of rehabilitation. OSM #3 stated in December 2020, Resident #22 had a static blue splint that had been working fine but then the splint caused redness and irritation. OSM #3 stated that type of splint "didn't give" (was not flexible). When asked how often the skin under splints should be assessed, OSM #3 stated the skin should definitely be assessed every shift and when the splints are removed for hygiene care.

On 3/17/21 at 3:56 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated splints should be removed daily for ADL (activities of daily living) care and nursing staff should be assessing the skin under splints

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when repositioning residents, when doing anything with the residents' bare skin or if residents are grimacing. LPN #4 was shown Resident #22's above referenced care plan and stated nurses should sign off that they are checking the skin under the resident's splints every shift.

On 3/17/21 at 4:29 p.m., another interview was conducted with LPN #4. LPN #4 stated she observed Resident #22's pressure injury on 12/15/20. LPN #4 stated the area was located in the crease of Resident #22's arm pit and was pink with purulent drainage and she could see the depth of the hole. LPN #4 stated the splint was not imbedded in the skin but was in contact with the skin. LPN #4 stated there wasn't any bone exposed and she inaccurately documented the pressure injury as a stage 4.

On 3/17/21 at 5:12 p.m., an interview was conducted with ASM (administrative staff member) #3 and
ASM #4 (both nurse practitioners). ASM #3 stated she and ASM #4 were together when they received a phone call regarding Resident #22's pressure injury on 12/15/20. ASM #3 stated she and ASM #4 did not see the pressure injury on that date but did provide verbal orders over the phone. ASM #3 stated that based on the description of the wound that the nurse gave over the phone, the wound was a worst case scenario stage 2.

On 3/17/21 at 5:19 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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The facility standard of practice, Lippincott Nursing Procedures 8th Edition documented, "Splint Application: Patient teaching- Tell the patient to check the skin beneath the splint several times per day..."

No further information was presented prior to exit.

References:

(1) "Anoxic brain damage is harm to the brain due to a lack of oxygen." This information was obtained from the website: https://www.winchesterhospital.org/health-library/article?id=96472

(2) "A contracture is a fixed tightening of muscle, tendons, ligaments, or skin. It prevents normal movement of the associated body part." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9218.htm

(3) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
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

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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 686	Continued From page 38 ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf	F 686		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, it	F 695		

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was determined that facility staff failed to provide respiratory care consistent with professional standards of practice, the comprehensive person-centered care plan for three of 52 residents in the survey sample, Residents # 47, # 58 and #35. The facility staff failed to administer oxygen to Resident # 47, #58 and #35 at the prescribed flow rate according to the physician's orders.

The findings include:

1. The facility staff failed to maintain Resident # 47's oxygen flow rate at three liters per minute according to the physician's orders.

Resident # 47 was admitted to the facility with diagnoses that include but not limited to: chronic obstructive pulmonary disease [1].

Resident # 47 was admitted to the facility with diagnoses that include but not limited to: chronic obstructive pulmonary disease (COPD) [1]. Resident # 47's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/22/2021, coded Resident # 47 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 47 as receiving "Oxygen Therapy" while a resident in the facility.

On 03/16/21 at approximately 11:59 a.m., Resident #47 was observed sitting in their wheelchair receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the

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oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

On 03/16/21 at approximately 3:11 p.m., a second observation by another surveyor revealed Resident sitting #47 receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

On 03/17/21 at approximately 9:00 a.m., an observation revealed Resident #47 sitting in their wheelchair receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

The physician's order dated 12/09/2019 for Resident # 47 documented, "O2 [oxygen] @ [at] 3L [three liters] via [by] NC [nasal cannula] [2] continuously r/t [related to] COPD.

The comprehensive care plan for Resident # 47 dated 09/11/2018 documented in part, "Focus Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease. Date Initiated: 09/11/2018. Under "Intervention" it documented in part, "Administer oxygen as needed per Physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. Date Initiated: 09/11/2018."

The eMAR [electronic medication administration record] for Resident # 47 dated March 2021 documented the above physician's order for oxygen. Further review of the eMAR documented that Resident # 47 received oxygen at three liters

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per minute on 03/16/2012 on the shifts of 7:00 a.m. 3:00 p.m., 3:00 p.m. to 11:00 p.m. and on 03/17/2021 on the 7:00 a.m. 3:00 p.m. shift.

On 03/17 2021 at approximately 1:32 p.m., an interview was conducted with RN [registered nurse] # 2, acting unit manager regarding the purpose of a resident's comprehensive care plan. RN # 2 stated that it [comprehensive care plan] was a guide to take care of the resident. After entering Resident #47's room and reading the oxygen flow meter on Resident #47's oxygen, RN # 2 stated the oxygen flow rate was set at two and a half liters per minute. When asked what the correct oxygen flow rate for Resident # 47 should be, RN # 2 then reviewed the physician's orders for Resident # 47 and stated that it should be three liters per minute.

On 03/17/2021 at approximately 5:05 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

[2] Tubing used to deliver oxygen at levels from 1 to 6 L/min. The nasal prongs of the cannula extend approx. 1 cm into each naris and are connected to a common tube, which is then connected to the oxygen source. This information was obtained from the website: http://medical-dictionary.thefreedictionary.com/na

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sal+cannula.

2. The facility staff failed to maintain Resident # 58's oxygen flow rate at two liters per minute according to the physician's orders.

Resident # 58 was admitted to the facility with diagnoses that include but not limited to: acute respiratory failure [1]. Resident # 58's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/22/2021, coded Resident # 58 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 58 as receiving "Oxygen Therapy" while a resident at the facility.

On 03/16/21 at approximately 12:06 p.m., Resident #58 was observed lying in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

On 03/16/21 at approximately 3:13 p.m., Resident # 58 was observed receiving oxygen via nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

On 03/17/21 at approximately 9:09 a.m., an observation of Resident #58 revealed the resident lying in bed receiving oxygen via a nasal cannula that was connected to an oxygen concentrator

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that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

The physician's order dated 01/29/2021 for Resident # 58 documented, "O2 [oxygen] @ [at] 2L/min [two liters per minute] continuously r/t [related to] SOB [shortness of breath].

The eMAR [electronic medication administration record] for Resident # 58 dated March 2021 documented the above physician's order for oxygen. Further review of the eMAR documented that Resident # 58 received oxygen at two liters per minute on 03/16/2012 on the shifts of 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. and on 03/17/2021 on the 7:00 a.m. to 3:00 p.m. shift.

The comprehensive care plan for Resident # 58 dated 02/01/2021 failed to evidence documentation for the use of oxygen.

On 03/17 2021 at approximately 1:32 p.m., an interview was conducted with RN [registered nurse] # 2, acting unit manager regarding the purpose of a resident's comprehensive care plan. RN # 2 stated that it [comprehensive care plan] was a guide to take care of the resident. After entering Resident #58's room reading the flow meter on Resident # 58's oxygen concentrator, RN # 2 stated the flow rate was two and a half liters per minute. When asked what the correct oxygen flow rate for Resident # 58 should be, RN # 2 then reviewed the physician's orders for Resident # 58 and stated that it should be two liters per minute.

On 03/17/2021 at approximately 5:05 p.m., ASM

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[administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1]When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

3. The facility staff failed to maintain Resident # 35's oxygen flow rate at four liters per minute according to the physician's orders.

Resident # 35 was admitted to the facility with diagnoses that include but not limited to: acute pulmonary edema [1].
Resident # 35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/14/2021, coded Resident # 35 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 35 as receiving "Oxygen Therapy" while a resident at the facility.

On 03/16/21 at approximately 11:38 a.m., an observation of Resident #35 revealed the resident in bed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

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On 03/17/21 at approximately 9:01 a.m., an observation of Resident # 35 revealed the resident was in bed receiving oxygen via nasal cannula connected to an oxygen concentrator that was running. Observation of the flow meter on the oxygen concentrator revealed an oxygen flow rate of two and a half liters per minute.

The physician's order dated 10/19/2020 for Resident # 35 documented, "Increase O2 [oxygen] to 4L four liters] via [by] nasal cannula continuously related to acute pulmonary edema.

The comprehensive care plan for Resident # 35 dated 06/13/2019 documented in part, "Focus" Alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease: I prefer to use the Incentive Spirometer as I need it and to keep it at my bedside. HX [history] abscess sinus, pulm [pulmonary] edema, copd [chronic obstructive pulmonary disease], lymes disease, asthma. Date Initiated: 06/13/2019." Under "Intervention" it documented in part, "Administer oxygen as needed per Physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. Date Initiated: 06/13/2019."

The eMAR [electronic medication administration record] for Resident # 35 dated March 2021 documented the above physician's order for oxygen. Further review of the eMAR documented that Resident # 35 received oxygen at four liters per minute on 03/16/2012 on the shifts of 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m. and 11:00 p.m. to 7:00 a.m. and on 03/17/2021 on the 7:00 a.m. to 3:00 p.m. shift.

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F 695	Continued From page 46 On 03/17 2021 at approximately 1:32 p.m., an interview was conducted with RN [registered nurse] # 2, acting unit manager, regarding the purpose of a resident's comprehensive care plan. RN # 2 stated that it [comprehensive care plan] was a guide to take care of the resident. After entering Resident # 35's room and reading the flow meter RN # 2 stated the oxygen flow rate on Resident #35's oxygen concentrator was two and a half liters per minute. When asked what the correct oxygen flow rate for Resident # 35 should be, RN # 2 reviewed the physician's orders for Resident # 35 and stated that it should be four liters per minute. On 03/17/2021 at approximately 5:05 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] An abnormal buildup of fluid in the lungs. This buildup of fluid leads to shortness of breath. This information was obtained from the website: https://medlineplus.gov/ency/article/000140.htm.	F 695		
F 698 SS=E	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:	F 698		

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Based on resident interview, clinical record review, facility document review and staff interview, it was determined that the facility staff failed to evidence a complete and current communication plan with the dialysis (1) center for one of three residents receiving dialysis, Resident #57.

The findings include:

Resident #57 was admitted to the facility with diagnoses that included but were not limited to end stage renal disease (2) and diabetes mellitus (3). Resident #57's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/28/2021, coded Resident #57 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.

On 3/17/2021 at approximately 9:35 a.m., an interview was conducted with Resident #57 in their room. Resident #57 stated that they go to the dialysis center on Tuesday, Thursday and Saturdays. Resident #57 stated that there was a book that was sent with them when they went to dialysis.

The physician's orders for Resident #57 documented in part, "Order Date: 8/6/2019 16:46 (4:46 p.m.) [Name/Address/Phone of Dialysis Center] on tues, thur-sat (Tuesday, Thursday, Saturday), Chair time 1230 pm..."

The progress notes for Resident #57 documented in part,

- "1/28/2021 13:51 (1:51 p.m.) ...out to dialysis."

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F 698	Continued From page 48 - "2/6/2021 10:12 (10:12 a.m.) ...gone to dialysis." - "2/9/2021 11:36 (11:36 a.m.) ...out to dialysis." - "2/13/2021 11:03 (11:03 a.m.) ...Note Text: patient at dialysis." - "2/16/2021 12:48 (12:48 p.m.) ...at dialysis." - "2/23/2021 10:25 (10:25 a.m.) ...at dialysis." - "3/6/2021 10:12 (10:12 a.m.) ...at dialysis." - "3/9/2021 16:14 (4:14 p.m.) ...Note Text: Resident returned from dialysis..." - "3/11/2021 09:53 (9:52 a.m.) ...Note Text: Resident left from dialysis..." - "3/13/2021 09:43 (9:43 a.m.) ...Note Text: Resident left from dialysis..." The comprehensive care plan for Resident #57 documented in part, "Focus- Alteration in Kidney Function evidenced by hemodialysis. Date Initiated: 05/03/2019..." On 3/18/2021 at approximately 8:25 a.m., a request was made to RN (registered nurse) #2 for the dialysis communication book for Resident #57. RN #2 was unable to find the book at the nurses' station and requested the book from another staff member who provided the book. RN #2 presented a binder and stated that the book was already in Resident #57's wheelchair for their dialysis appointment that morning. Review of the dialysis communication book revealed a binder with Resident #57's name, dialysis schedule and dialysis location on the front of the binder. The binder contained pages titled "Dialysis Communication Record" for Resident #57. The most current "Dialysis Communication Record" observed in the binder was dated "1/26" (1/26/2021). The binder further contained an	F 698		

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"Order Summary Report" dated "Sep 30, 2020" (9/30/2020) which documented, "Active Orders as of: 09/30/2020." Review of the binder failed to evidence current physician orders for Resident #57 and dialysis communication records completed after 1/26/2021. Further review of the dialysis communication forms for Resident #57 from 12/1/2020-3/16/2021, a period of 46 Tuesday, Thursday and Saturday dialysis treatments, evidenced that 33 out of 46 (72%) of the dialysis communication forms were missing.

On 3/18/2021 at approximately 8:35 a.m., an interview was conducted with LPN (licensed practical nurse) #6. LPN #6 stated that they fill out a dialysis form and send the form with Resident #57 each day that the resident went to dialysis. LPN #6 stated that the form was completed to communicate any concerns or changes. LPN #6 stated that Resident #57 went to dialysis three days a week, on Tuesdays, Thursdays and Saturdays. LPN #6 stated that there were times when the book did not come back from dialysis with Resident #57 and they would just send the paper with Resident #57. LPN #6 stated that they did not copy the paper when this happened or call dialysis. LPN #6 reviewed the dialysis communication book for Resident #57 and stated that there were no communication records after 1/26/2021. LPN #6 stated that they could not say why they were not in the book and to ask RN #2.

On 3/18/2021 at approximately 845a.m., an interview was conducted with RN #2. RN #2 stated that the staff should have filled out a dialysis communication form before each dialysis appointment. RN #2 reviewed the dialysis communication book for Resident #57 and stated

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that there were no communication records after 1/26/2021. RN #2 stated that the physician orders were updated monthly and should have been updated in the book monthly. RN #2 stated that the communication forms for Resident #57 should be in the book and she could not say why they were not there.

On 3/18/2021 at approximately 9:45 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the dialysis contract and the facility policy for dialysis communication.

On 3/18/2021 at approximately 1:55 p.m., ASM #1 provided via email, "Long Term Care Facility Outpatient Dialysis Services Coordination Agreement" dated 5/23/2019. The agreement documented in part, "...11. Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the Long Term Care Facility and ESRD (end stage renal disease) Dialysis Unit..."

The facility policy, "Coordination of Hemodialysis" dated "Effective Date: 2/2017, Revision Date: 1/2020" documented in part, "...1. A communication format will be initiated by the facility for any resident going to an ESRD facility for hemodialysis..." The policy further documented, "...2. Nursing will collect information regarding the resident to send to the ESRD facility with the resident- information recommended but not limited to: A. Resident information- face sheet. B. Copy of current physician orders..."

On 3/18/21 at approximately 9:00 a.m., ASM #1,

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F 698	Continued From page 51 the administrator was made aware of the findings. No further information was provided prior to exit. References: 1. Hemodialysis: Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm. 2. End-stage kidney disease: The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. 3. Diabetes mellitus: A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 698		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		

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requirements of §483.95(g).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and employee record review, it was determined the facility staff failed to complete annual performance reviews and competencies for six of 22 CNAs (certified nursing assistants) that were employed for greater than one year, CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, and CNA #8.

The findings include:

A request was made on 3/16/2021 at 4:36 p.m. for the annual evaluations and a copy of the recent competencies completed for CNA #3, CNA #4, CNA #5, CNA #6, CNA #7, and CNA #8.

CNA hire dates are as followed:
CNA #3 - 12/16/2016
CNA #4 - 12/16/2016
CNA #5 - 12/16/2016
CNA #6 - 12/16/2016
CNA #7 - 12/16/2016
CNA #8 - 1/24/2019

ASM (administrative staff member) #1, the administrator, sent an email that documented, "The HR (human resources) manager could not locate the annual evaluations and competencies for CNA #3, CNA #4, CNA #5, CNA #6, and CNA #8. An annual "Performance Review Form" was located on CNA #7. The "Performance Review Form" was dated 2/19/19.

On 3/17/2021 at 2:01 p.m., the administrator was asked by email which staff was responsible for the annual performance and competency reviews of the CNAs.

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On 3/17/2021 at 2:25 p.m. ASM #1 responded stating, for annual reviews and competencies, they would be completed by their respective department director, so for nursing it would be the DON (director of nursing).

An interview was conducted with ASM #2, the DON, on 3/18/2021 at 11:29 a.m. When asked how often evaluations are completed, ASM #2 stated at least yearly. When asked how often competencies are completed, ASM #2 stated at least yearly. When asked why they have not been completed since 2019 or longer, ASM #2 stated she had only been employed at the facility for three months. When asked who is responsible for completing the CNA evaluations, ASM #2 stated, ultimately, it's the DON but the unit managers can do them also. When asked how often competencies are completed, ASM #2 stated they should be done annually and she had already set up a skills fair for next month.

The facility policy, "Performance Evaluations" documented in part, "1. Performance evaluations are conducted in privacy and will be used as a tool in determining employee promotions, shift/position transfers, demotions, terminations, wage increases, etc., and to improve the quality of the employee's work performance and development. 2. A Performance evaluation must be completed on each employee within 30 days of their original service date utilizing the Annual Performance Review Forms - employee and management."

ASM #1, the administrator, was made aware of the above concern on 3/18/2021 at 2:24 p.m.

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F 730	Continued From page 54 No further information was provided prior to exit.	F 730		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, it was determined that the facility staff failed to ensure the medication regimen was free from unnecessary medications for one of 52 residents in the survey sample, Resident # 35. The facility staff failed to attempt or implementation non-pharmacological interventions prior to the administration of as needed pain medication to Resident #35.	F 757		

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The findings include:

Resident # 35 was readmitted to the facility with diagnoses that included but were not limited to: cancer of the vulva [1] and pain. Resident # 35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/14/2021, coded Resident # 35 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section "J0300, J0400 and J0600 Pain Assessment Interview" coded Resident # 35 as having frequent pain at a level of 5 [five] on a pain scale of zero to ten, with ten being the worse pain.

The current physician's order dated 01/09/2020 documented, "Acetaminophen Tablet 325 MG [milligrams]. Give two tablets by mouth every 4 [four] hours as needed for pain. Not to exceed 3000 G [grams] in a 24 hour period."

Resident # 35's eMAR [electronic medication administration record] dated January 2021 documented the physician's order as above. The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Acetaminophen on: 01/23/2021 at 2:11 p.m. with a pain level of eight, 01/24/2021 at 11:51 a.m. with a pain level of six, 01/25/2021 at 10:49 a.m. with a pain level of six, 01/27/2021 at 12:17 p.m. with a pain level of six, 01/28/2021 at 8:55 p.m. with a pain level of three and on 01/31/2021 at 9:05 p.m. with a pain level of two.

Resident # 35's eMAR [electronic medication administration record] dated February 2021

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documented the physician's order as above. The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Acetaminophen on: 02/04/2021 at 4:36 p.m. with a pain level of four, 02/10/2021 at 1:39 a.m. with a pain level of three, 02/21/2021 at 8:30 a.m. with a pain level of four and at 12:45 p.m. with a pain level of six, 02/23/2021 at 8:33 a.m. with a pain level of six and on 02/24/2021 at 8:21 a.m. with a pain level of six.

Resident # 35's eMAR [electronic medication administration record] dated March 2021 documented the physician's order as above. The eMAR failed to evidence documentation of non-pharmacological interventions. Further review of the eMAR revealed the administration of Acetaminophen on: 03/01/2021 at 5:27 a.m. with a pain level of six, 03/13/2021 at 7:43 a.m. with a pain level of six and at 4:51 p.m. with a pain level of two, 03/14/2021 at 5:37 p.m. with a pain level of five.

The comprehensive care plan for Resident # 35 dated 05/09/2019 documented in part, "Focus: Needs Pain management and monitoring related to: Cancer. Date Initiated: 11/08/2018." Under "Interventions" it documented in part, "Implement the patient's preferred non-pharmacological pain relief strategies. Date Initiated: 11/08/2018."

On 03/16/21 at approximately 11:38 a.m., an interview was conducted with Resident # 25. When asked if they are provided with non-pharmacological strategies to in an attempt to alleviate their pain before being given pain medication, Resident # 35 stated that the nurse will ask what their pain level is and give them the

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pain medication.

Review of Resident # 35's progress notes dated 01/01/2021 through 03/17/2021 failed to evidence documentation of provided or attempted non-pharmacological interventions prior to the administration of as needed acetaminophen.

On 03/18/21 at 8:05 a.m., an interview was conducted with RN [registered nurse] # 2, acting unit manager, regarding the procedure staff follows when administering as needed pain medication to a resident. RN # 2 stated ask the resident their pain level on a scale one to ten with one being minor pain and ten being unbearable, ask where the pain is and offer an intervention before giving the pain medication and if it doesn't work give the pain medication and follow up in about half an hour. When asked where staff document the non-pharmacological interventions attempted or provided, RN # 2 stated that they document them on the progress notes. After reviewing the eMARs dated January, February and March 2021 and progress notes for Resident # 35 for the above dates RN # 2 stated there was no documentation of non-pharmacological interventions being attempted. When asked about the lack of documentation of non-pharmacological interventions, RN # 2 stated, "Without documentation I can't say it was being done."

On 03/17/2021 at approximately 5:05 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

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F 757	Continued From page 58 References: [1] Used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a681004.html. [2] A rare type of cancer. It forms in a woman's external genitals, called the vulva. This information was obtained from the website: https://medlineplus.gov/vulvarcancer.html.	F 757		
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 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	F 761		

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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, resident interview, staff interview, clinical interview and facility document review it was determined facility staff failed to secure prescribed medications for one of 52 residents in the survey sample, (Resident #104) and failed to label and store drugs and biologicals in a safe and secure manner in two of six medication carts, (Wing A medication cart-one, Wing A medication cart-two), and failed to ensure expired medications and biologicals were not available for use, in two of six medication carts and one of three medication storage rooms, (Wing A medication cart-one, Wing A medication room and Wing B medication cart-one).

The findings include:

1. The facility staff failed to secure a Ventolin (1) and a Breo (2) inhaler that were available for use on a folding table inside of Resident #104's room.

Resident #104 was admitted to the facility with diagnoses that included but were not limited to malignant neoplasm of the lung (3) and chronic obstructive pulmonary disease (COPD) (4). Resident #104's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/2/2021, coded Resident #104 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions.

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On 3/16/2021 at approximately 12:12 p.m., an observation was made of Resident #104's room. Resident #104's room door was observed open and the was not observed in the room. Two inhalers, a Breo inhaler and a Ventolin inhaler, were observed on a white folding table located against the wall between the bed and the window.

On 3/16/2021 at approximately 2:36 p.m., an interview was conducted with Resident #104 in their room. The Breo and Ventolin inhaler were observed on the white folding table located between Resident #104's bed and the window. Resident #104 stated that they did use both of the inhalers but refused to say when they had last used them or how often they used them. Resident #104 stated that they were finished answering questions and requested the surveyor to leave.

Additional observations on 3/16/21 at 4:36 p.m. and 3/17/21 at 9:20 a.m. revealed the Breo and Ventolin inhalers located on the white folding table located inside of Resident #104's room. Resident #104's room door was observed open on each occasion.

The physician's orders for Resident #104 documented in part, "3/16/2021 14:08 (2:08 p.m.) Breo Elipta Aerosol Powder Breath Activated 100-25 MCG/INH (microgram/inhalation) (Fluticasone Furoate-Vilanterol) 1 (one) puff inhale orally one time a day related to Malignant Neoplasm of Unspecified part of unspecified bronchus or lung until 03/28/2021 23:59 (11:59)." The physician's orders further documented, "12/23/2020 12:14 (12:14 p.m.) Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT 2

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(two) puff inhale orally every 6 hours as needed for SOB (shortness of breath)." The physician's orders failed to evidence documentation of Resident #104 being allowed to store the inhalers in their room or self administer the medication.

The electronic medication administration record (eMAR) dated 3/1/2021-3/31/2021 for Resident #104 documented the Breo inhaler received at 9:00 a.m. each day from 3/1/2021 through 3/21/2021. The eMAR further documented Resident #104 receiving the Albuterol inhaler every six hours from 3/1/2021 through 3/7/2021 and every four hours from 3/9/2021 through 3/14/2021.

The comprehensive care plan for Resident #104 documented in part, "Alteration in Respiratory status due to Chronic Obstructive Pulmonary Disease, due to lung cancer. I had a left lobectomy. Date Initiated: 08/25/2020..."

On 3/17/2021 at approximately 1:25 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated that Resident #104 had prescribed inhalers that were kept on the medication cart. RN #2 stated that inhalers were not supposed to be stored in the residents rooms. RN #2 stated that Resident #104 was not cleared for self-administration of medications and that an assessment would have to be completed first. RN #2 stated that as far as they knew there were no residents in the facility that self-administered their medications.

On 3/17/2021 at approximately 1:30 p.m., RN #2 observed the Breo and Ventolin inhaler located on the white folding table between Resident #104's bed and the window in their room. RN #2 spoke

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to Resident #104 and requested permission to remove the inhalers. Resident #104 gave RN #2 permission to remove the inhalers.

On 3/17/2021 at approximately 1:45 p.m. an interview was conducted with LPN (licensed practical nurse) # 2. LPN #2 stated that residents who self-administer medications would require an order from the physician and have an assessment completed. LPN #2 stated that the facility does not typically allow residents to self-administer medication. LPN #2 stated that medications were stored in the medication room on each unit and in the supply rooms. LPN #2 stated that there were no medications stored in resident rooms because they did not want them to over administer the medication or anyone else to get the medication. LPN #2 stated that they were not sure of the process for self-administration of medication because they had never had to do it.

On 3/17/2021 at approximately 5:05 p.m., ASM (administrative staff member) #2, the director of nursing stated that the facility used Lippincott as their standard of practice.

On 3/18/2021 at approximately 9:45 a.m., a request was made to ASM #1, the administrator for the facility policy for storage of medications.

On 3/18/2021 at approximately 1:55 p.m., ASM #1 provided via email, "Medication Storage Storage of Medication 11/17." The policy documented in part, "...3. In order to limit access to prescription medications, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts.

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Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access..."

Fundamentals of Nursing, Lippincott, Williams & Wilkins 5th edition; page 557 under the section "Nurse Practice Acts", "Nurses are also expected to practice in a safe and prudent manner ....it is the nurse's legal domain to administer medications in a safe and timely manner. "Page 568, "Procedure 29-1; Administering Oral Medications". Procedure: 1. Wash hands. 2. Arrange MAR next to medication supply. 3. Prepare medications for only one client at a time. 4. Remove ordered medications from supply ....5. Calculate correct drug dosage ....6. Prepare selected medications ...7. Take medication directly to client's room. Do not leave medication unattended."

On 3/17/21 at approximately 5:05 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Ventolin (Albuterol) is a bronchodilator used to prevent or treat bronchospasm in patients with reversible obstructive airway disease. Nursing 2010 Drug Handbook, Lippincott, Williams & Wilkins, page 834.

2. Breo Ellipta inhalation powder contains a combination of fluticasone and vilanterol. Fluticasone is a steroid that prevents the release of substances in the body that cause

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inflammation. Vilanterol is a bronchodilator that works by relaxing muscles in the airways to improve breathing. This information was obtained from the website: https://www.drugs.com/breo-ellipta.html

3. Malignant neoplasm: The term "malignancy" refers to the presence of cancerous cells that have the ability to spread to other sites in the body (metastasize) or to invade nearby (locally) and destroy tissues. Malignant cells tend to have fast, uncontrolled growth and DO NOT die normally due to changes in their genetic makeup. Malignant cells that are resistant to treatment may return after all detectable traces of them have been removed or destroyed. . This information was obtained from the website: https://medlineplus.gov/ency/article/002253.htm.

4. Chronic obstructive pulmonary disease (COPD) is a disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. The facility staff failed to ensure medications and biologicals were labeled and stored in a safe, secure manner according to professional standards. Fifteen and a half loose unidentified pills were observed in the drawers of the Wing A-medication cart-one, thirty-two loose pills were observed in the drawers of the Wing A-medication cart-two and expired medications and biologicals were observed available for use in the Wing A, medication cart-one, Wing B, medication cart-one, Wing A medication room.

On 3/16/21 at approximately 11:25 AM an observation of the Wing- A medication room and

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the Wing-A medication cart-one located in the medication room was conducted with LPN (licensed practical nurse) #2 and LPN #1. Observation inside the drawers of the Wing-A medication cart-one revealed the following:
- Drawer one: five loose unidentified pills.
- Drawer two: nine and a half loose unidentified pills,
- Drawer four revealed one loose unidentified pill.

Observation inside the drawers of Wing-A medication cart-two revealed the following:
- Drawer one: seventeen loose unidentified pills.
- Drawer two: seven loose unidentified pills,
- Drawer three: four and one half loose pills,
- Drawer four revealed three and one half loose unidentified pills.

The loose pills in each drawer above were observed located behind the medication cards stored in each drawer. When asked about the loose medications in the drawer, LPN #2 stated, "Sometimes they pop out of the medication cards that is the problem with the cards".

Further observation of the Wing-A, medication cart-one revealed, in the first side drawer of the cart the following:
- One bottle of Assure control solution (for glucose monitoring system) (4) with expiration date of 3/16/18.

In the Wing A, medication room grey storage cabinet, an unopened full bottle of Naproxen (analgesic, non-steroidal anti-inflammatory) (1) 220 milligram- 100 tablets with expiration date of 2/2021, was found.

An interview was conducted on 3/16/21 at 11:30

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AM with LPN (licensed practical nurse) #2. When asked about the expiration date on the Assure control and the Naproxen bottle, LPN #2 stated, "They are both expired".

An interview was conducted on 3/16/21 at approximately 11:41 AM with LPN #1, regarding the loose unidentified pills observed in the medication cart drawers of the Wing-A medication cart-one. LPN #1 stated, "This is not my usual cart. They sometimes just come out of the cards".

On 3/16/21, at approximately 12:00 noon, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked who is responsible to check medications for expiration, ASM #2 stated, "Nursing is responsible to check the medications and dispose of them if they are expired". When asked what standard of practice the facility followed, ASM #2 stated, "We follow Lippincott".

On 3/16/20 at approximately 2:25 PM, an observation of the Wing B medication room and the Wing-B, medication cart-one was conducted with LPN #3. Observation inside the drawers of the Wing-B medication cart-one, in the first side drawer, revealed the following:
- One bottle of Assure control solution for (glucose monitoring system) control was dated as opened on 11/28/20 (note: expiration date is 90 days from being opened) expired 2/26/21,
- One bottle of lidocaine (local anesthetic) (5)1% opened on 9/12/20 with bottle expiration date 2/26/21.
- One vial of Humalog (insulin) (2) U-100, labelled with an opened on 1/22/21,
- One bottle of Fluticasone Propionate

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(corticosteroid nasal inhaler) (3) Suspension 50 microgram/nasal spray with an expiration date of 1/2021.

An interview was conducted on 3/16/21 at 2:25 PM with LPN #3. When asked to verify the expiration dates on the Assure, Lidocaine, Insulin and Fluticasone Propionate Suspension, LPN #3 stated, "I see the opened dates, you should check with the unit manager to see when they expire".

An interview was conducted on 3/16/21 2:25 PM with LPN #4, the unit manager. When asked to verify the expiration dates on Assure, Lidocaine, Insulin and Fluticasone Propionate Suspension, LPN #4 stated, "Yes, they are all expired, they should have been thrown out". When asked about the expiration period of an opened vial of insulin, LPN #4 stated, "It is 30 days unless the manufacturer states otherwise, like with the Assure control".

ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were informed of the loose medications, expired medications and biologicals on 3/17/21 at 5:05 PM.

According to the facility's "Medication Storage" policy, which documents in part, "Outdated, contaminated, discontinued or deteriorated medications are immediately removed from stock, disposed of according to procedures for medication disposal".

The Humalog manufacturer's website documented, in part: "16.2 Storage and Handling ... In-use HUMALOG vials, cartridges, and HUMALOG prefilled pens should be stored at

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F 761	Continued From page 68 room temperature, below 86°F (30°C) and must be used within 28 days or be discarded, even if they still contain HUMALOG." This information was obtained from the website: https://pi.lilly.com/us/humalog-pen-pi.pdf No further information was provided prior to exit. References: (1) 2019 Lippincott Pocket Drug Guide for Nurses, Wolters, Kluwer, page 258. (2) 2019 Lippincott Pocket Drug Guide for Nurses, Wolters, Kluwer, page 193. (3) 2019 Lippincott Pocket Drug Guide for Nurses, Wolters, Kluwer, page 437. (4) Assure control package insert. (5) 2019 Lippincott Pocket Drug Guide for Nurses, Wolters, Kluwer, page 216. (6) Lippincott Nursing Procedures, 8th edition, Wolters, Kluwer, page 556.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		

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that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for three of 52 residents in the survey sample, Residents #22, #118 and #35.

The findings include:

1. The facility staff failed to document the accurate stage of a pressure injury that Resident #22 developed on 12/15/20

Resident #22 was admitted to the facility on 4/27/12. Resident #22's diagnoses included but were not limited to anoxic brain damage (1), contractures (2) of the right elbow, left elbow and right hand, and anxiety disorder. Resident #22's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/1/21 coded the resident's cognitive skills for daily decision making as severely impaired. Section M coded the resident as having a stage 2 pressure injury (3).

Review of Resident #22's clinical record revealed

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a nurse's note dated 12/15/20 that documented, "Situation: open area under right under arm. Background: contracted, wear arm splint. Assessment: aide was providing care for resident when she alerted writer to an open area under residents right arm- open area is 0.6 x (times) 0.5 x 0.1, with a sour odor and purulent drainage. tissue (sic) to area is very thin and fragile with discoloration (bright purplish red in color), area is tender to touch while writer and aide are attempting to maneuver residents (sic) arm to have clear access to open area. Response: NP (nurse practitioner) made aware of event, NOO (new order obtained) to remove splint and orders for treatment..."

An initial pressure injury record dated 12/15/20 documented a stage 4 (3) pressure injury measuring 0.6 cm (centimeters) in length by 0.5 cm in width by 0.1 cm in depth on Resident #22's right upper arm.

On 3/17/21 at 3:56 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (the nurse who documented the 12/15/20 note and 12/15/20 initial pressure injury record). LPN #4 stated on 12/15/20, when Resident #22's pressure injury was first observed, it was pink with purulent drainage and she could see the depth of the hole. LPN #4 stated there wasn't any bone exposed and she inaccurately documented the pressure injury as a stage 4.

On 3/17/21 at 5:12 p.m., an interview was conducted with ASM (administrative staff member) #3 and
ASM #4 (both nurse practitioners). ASM #3 stated she and ASM #4 were together when they received a phone call regarding Resident #22's

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pressure injury on 12/15/20. ASM #3 stated she and ASM #4 did not see the pressure injury on that date but did provide verbal orders over the phone. ASM #3 stated that based on the description of the wound that the nurse gave over the phone, the wound was a worst case scenario stage 2.

On 3/17/21 at 5:19 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility skin program policy documented, "All open areas will be identified and documented on the appropriate forms- Pressure Ulcer Record/Non-Decubitus Skin Condition Record...All skin conditions will be assessed weekly with documentation of: Stage..."

No further information was presented prior to exit.

References:

(1) "Anoxic brain damage is harm to the brain due to a lack of oxygen." This information was obtained from the website: https://www.winchesterhospital.org/health-library/article?id=96472

(2) "A contracture is a fixed tightening of muscle, tendons, ligaments, or skin. It prevents normal movement of the associated body part." This information was obtained from the website: https://medlineplus.gov/ency/imagepages/9218.htm

(3) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other

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device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
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. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf
2. The facility staff failed to document the assessment completed to pronounce Resident #118's death on 3/3/2021, and failed to document notification to the nurse practitioner and the

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disposition of the resident after death.

Resident #118 was admitted to the facility on 4/1/2020 with a recent readmission on 12/30/2020 with diagnoses that included but were not limited to: high blood pressure, dementia (1), pain, depression and atrial fibrillation. (2)

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/1/2021, coded the resident as having both long and short term memory difficulties and was coded as being severely impaired to make daily cognitive decisions. Resident #118 was coded as requiring extensive assistance to being dependent upon one or more staff members for all of her activities of daily living. In Section O - Special Treatments, Procedures and Programs, the resident was coded as receiving hospice care.

A nurse's note dated 3/3/2021 at 2:10 p.m. documented, "Resident observed laying (sic) in bed no breath sounds, no rise and fall in chest, no pulse. Adon (assistant director of nursing) in room with resident to call time of death for 2 pm on 3/3/21. (Name of hospice) called and stated nurse coming out to evaluate. Staff in room to clean resident."

On 3/18/2021 at 11:07 a.m., an interview was conducted with LPN (licensed practical nurse) #4 regarding the process staff follows when a resident passes away. LPN #4 stated the nurse checks first if the resident is a full code or a DNR (do not resuscitate). If a DNR, the nurse, if not an RN (registered nurse) calls an RN to come pronounce the resident's death. When asked who documents the death, LPN #4 stated the nurse

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can write a note but the RN that does the pronouncement is supposed to write a note. When asked if a nurse does any type of assessment, should they write a note, LPN #4 stated, yes, that is nursing practice.
When asked if a note should be written about who was notified of the death, and that the resident's body has been released to the funeral home, LPN #4 stated, yes and it should include the name of the funeral home and what personal items went with the resident to the funeral home, such as dentures, rings.

An interview was conducted with LPN #3 on 3/18/2021 at 11:22 a.m. When asked if a resident dies, who should she notify, LPN #3 stated she calls the family, doctor or nurse practitioner, DON (director of nursing), unit manager, and hospice if they are on hospice. The progress note she wrote on 3/3/2021 at 2:10 p.m. was reviewed with LPN #3. When asked if she notified the doctor or nurse practitioner, LPN #3 stated, "I can't remember. To my knowledge, I think I did. I can't remember." When asked if notification to the family, physician or nurse practitioner should be documented in the chart, LPN #3 stated that yes there should be a note. When asked if a note should be written when the resident's remains are taken to the funeral home, LPN #3 stated that she asked but no one could give her an answer. She further stated that Resident #118 was still in the facility when she left at the end of her shift. She was probably picked up by the funeral home on the next shift.

An interview was conducted with ASM (administrative staff member) #2, the DON, on 3/18/2021 at 11:29 a.m. When asked who documents the death of a resident in the clinical

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record, ASM #2 stated the LPN can write their own note but the nurse that does the pronouncement must write a note. When asked who notifies the family or doctor, ASM #2 stated either the LPN or the nurse that pronounced the resident's death can notify both the family and doctor. When asked if there should be a progress note in the record that documents that the family and doctor have been notified, ASM #2 stated, "Yes, there should be." The progress note dated 3/3/2021 at 2:10 p.m. was read to ASM #2. When asked if there should be a note by the ADON, ASM #2 stated that there should be. When asked if a progress note should be written when the resident's remains are released to the funeral home, ASM #2 stated that there should be a note to say that the resident was released to the name of the funeral home.

The ADON who declared the resident's death was no longer employed by the facility and was unavailable for interview.

An interview was conducted on 3/18/2021 at 12:22 p.m. with ASM #3, the nurse practitioner. ASM #3 stated that she had received a call from (LPN #3) on 3/3/2021 at 2:14 p.m. She stated she was shocked by the news because she had just been discussing the resident with the other nurse practitioner of how good she had looked that morning. ASM #3 stated, the staff always call us with a death of a resident.

The facility provided a policy, "Documentation" taken from Lippincott Nursing Procedures, 8th edition, page 236 that documented, "Documentation is the process of preparing a complete record of a patient's care and is a vital tool for communication among health care team

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members. Accurate, detailed documentation show the extent and quality of the care that nurses provide the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors."

ASM #1, the administrator, was made aware of these findings on 3/18/2021 at 2:24 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55..
3. Resident #35's clinical record contained an incomplete "Virginia Advanced Directive" form. The form failed to evidence the resident's preferences for health care instructions.

Resident # 35 was readmitted to the facility with diagnoses that included but were not limited to: cancer of the vulva [1], pulmonary edema [2] and pain. Resident # 35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/14/2021, coded Resident # 35 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

On 03/17/21 at approximately 9:15 a.m., a review of Resident # 35's clinical record revealed a form titled, "Virginia Advance Directive" that

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documented Resident # 35's name and the primary agent. Review of the form revealed it was blank and failed to evidence the resident's preferences for health care instructions.

The comprehensive care plan for Resident # 35 dated 05/09/2019 documented, "Focus: Patient has an advance directive as evidenced by full code. Date Initiated: 05/09/2019." Under "Interventions" it documented in part, "CPR [cardiopulmonary resuscitation] will be performed as ordered. Date Initiated: 05/09/2019."

The current physician's order sheet dated 03/2021 documented, "Code Status: Full Code."

On 03/17/21 at 9:23 a.m., an interview was conducted with RN [registered nurse] # 2 , acting unit manager. When asked who was responsible for completing a resident's advance directive RN # 2 stated that it was completed upon admission by the nurse and that the unit managers follow up to make sure it's completed. After reviewing the advance directive for Resident # 35, RN # 2 agreed it was incomplete.

On 03/17/2021 at approximately 5:05 p.m., ASM [administrative staff member] # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A rare type of cancer. It forms in a woman's external genitals, called the vulva. This information was obtained from the website: https://medlineplus.gov/vulvarcancer.html.

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F 842	Continued From page 79 [2] An abnormal buildup of fluid in the lungs. This buildup of fluid leads to shortness of breath. This information was obtained from the website: https://medlineplus.gov/ency/article/000140.htm.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	F 883		

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immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to assess two of five residents in the immunization review, Residents # 75 and # 46.

The findings include:

1. For Resident #75, the facility staff failed to offer and provide the resident the opportunity to receive or decline the influenza vaccine for this influenza season.

Resident #75 was admitted to the facility on 8/15/2019 with diagnoses that included but were not limited to: stroke (1), paraplegia (2), and high

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blood pressure.

The most recent MDS (minimum data set) assessment, with an assessment reference date of 2/10/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as not receiving an influenza vaccination and the reason documented was "Offered and declined."

Review of the electronic medical record revealed under the Immunization tab the following was documented, "consent refused."

On 3/16/2021 at 4:36 p.m., a request was made for the documentation of Resident #75's education and denial to receive his influenza vaccine.

A copy of Resident #75's "Consent Form - Influenza and pneumococcal conjugate vaccine" was provided. Review of this form documented the form was signed on 10/24/2019.

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 3/18/2021 at 11:29 a.m., regarding the process staff follows for obtaining consents for influenza vaccinations. ASM #2 stated they are offered annually. Resident #75's form that was provided was reviewed with ASM #2. ASM #2 was asked to provide Resident #75's education for, consent and or denial to receive his influenza

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vaccination for the current influenza season.

On 3/18/2021 at 2:08 p.m. ASM #2 contacted this surveyor and stated that she could not find a form signed for this year. ASM #2 stated she talked to Resident #75 and had him sign a form refusing the influenza vaccine for this influenza season.

The facility policy, "Influenza Vaccine - Resident Health Program" documented in part, "All residents will be offered an Influenza Vaccine according to local health department guidelines: Obtain physician's order. Offer the resident the influenza vaccine if medically indicated. Obtain an Informed Consent for the resident or responsible party if indicated. Explain the potential risks/side effects/benefits of the vaccine. Be aware these change annually. You can pull current information from the CDC website. Have resident/responsible party sign the consent, indicating the desire to receive the vaccine or the wish to decline."

ASM #1, the administrator was made aware of the above concern on 3/18/2021 at 2:24 p.m.

No further information was provided prior to exit.

(1) Stroke or CVA abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death. This information was obtained from: Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.

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(2) Paraplegia is paralysis of the lower limbs, sometimes accompanied by loss of sensory and/or motor function in the back and abdominal region below the level of the injury. This information was obtained from: Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 435.

2. For Resident #46, the facility staff failed to offer and provide the resident the opportunity to receive or decline the pneumococcal vaccination and failed to ensure the residents medical record included documentation that resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

Resident #46 was admitted to the facility on 8/28/2018 with diagnoses that included but were not limited to: COPD (chronic obstructive pulmonary disease -general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), high blood pressure and schizophrenia. (2)

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 1/22/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded in Section O - Special Treatments, Procedures, and Programs as not receiving a pneumococcal vaccination while in the facility and the reason documented, "Not eligible - medial contraindication."

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Review of the electronic medical record, failed to evidence any documentation related to the pneumococcal vaccine.

A request was made for the documentation of Resident #46's education and consent for her pneumococcal vaccine 3/16/2021 at 4:36 p.m.

A copy of Resident 46's "Consent Form - Influenza Vaccine and Pneumococcal Conjugate Vaccine" documented a signature of the resident under the Pneumococcal Polysaccharide Vaccine. They was no date documented. There was no indication if the resident wanted or did not want the vaccine.

An interview was conducted with ASM (administrative staff member) #2 on 3/18/2021 at 11:29 a.m., regarding the process staff follows for assessing the resident's pneumococcal status. ASM #2 stated the admissions staff would assess immunization when they enter the facility but the nurses should follow up on them also. When asked if the consent forms should be fully completed, ASM #2 stated, yes. ASM #2 stated the nurse should ensure the form is completely filled in for the resident's wishes regarding the vaccine before it is filed in the clinical record. Resident #46's consent form was reviewed with ASM #2.

On 3/18/2021 at 2:08 p.m., ASM #2 stated she could not find any other documentation related to Resident #46's pneumococcal vaccinations. She went and spoke with Resident #46 and she declined the pneumococcal vaccine and signed, dated and documented her wishes on the new form.

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The facility policy, "Pneumococcal Vaccinations" documented in part, "All residents admitted to the facility will be given the opportunity to receive the pneumococcal vaccine per physician's order. The pneumococcal vaccine should be given only every 5 years to the resident. The admitting nurse will research the medical record and resident history to determine if pneumococcal has ever been given. After determining that the vaccine has not been given the pneumococcal vaccine within 5 years, the admitted nurse will obtain an order for the vaccine from the attending physician and consent from the resident or responsible party of indication."

ASM #1, the administrator, was made aware of the above concern on 3/18/2021 at 2:24 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(2) Schizophrenia: Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response. This information was obtained from: Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522.