DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. BUILDING _____ B. WING _____	C 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

(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 07/27/2021 through 07/29/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/27/2021 through 7/29/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four complaints (VA00050669- substantiated with deficiency, VA00051556- substantiated without deficiency, VA00049849- unsubstantiated and VA00050230- unsubstantiated), were investigated during the survey. The census in this 125 certified bed facility was 117 at the time of the survey. The survey sample consisted of 49 resident reviews.	F 000	**Glenburnie Rehabilitation and Nursing Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence to comply with the requirements of participation and effort to provide high quality resident centered care.**	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550	**F550: Residents Rights/Exercise of Rights** 1. Resident #104 continues to reside in facility and the catheter collection bag has been placed on the back of the wheelchair below the level of the bladder. 2. All residents leaving facility for appointments/outings have the potential to be affected by this alleged deficient practice. Audit conducted by nursing management to ensure all residents with a foley catheter collection bag are placed below the bladder and in a discrete location as possible. 3. DON or designee will re-educate all nursing staff that all residents with a foley catheter collection bag are placed below the bladder and in a discrete location as possible.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 8/25/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a resident's dignity by appropriately placing a resident's catheter collection bag in a discreet location one of 49 residents in the survey sample, Resident # 104. The facility staff placed Resident # 104's catheter collection bag on the front of the control arm of	F 550	4. DON or designee will audit residents with a foley catheter collection bag for appropriate placement below the bladder and in a discrete location to promote Resident's dignity weekly times 4 and monthly times 2 to ensure residents have on appropriate outerwear when leaving facility on appointments/outings. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be August 20, 2021.	

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F 550	Continued From page 2 their power wheelchair. The findings include: Resident # 104 was admitted to the facility with diagnoses that included but were not limited to: Parkinson's disease [1] and multiple sclerosis [2]. Resident # 104's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 07/08/2021, coded Resident # 104 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Resident # 104 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section H "Bladder and Bowel" Resident # 104 was coded under "H0100" as having an indwelling catheter and an external catheter. Observations of Resident # 104 conducted on 07/27/21 at 11:45 a.m., 1:05 p.m., and at 2:05 p.m., revealed the resident was sitting in their power wheelchair. Observation of the wheelchair revealed the catheter collection bag was hanging on the front of the control arm of power wheelchair. Further observation of the catheter collection bag revealed that it was at the height of Resident # 104's navel while they were sitting in their wheelchair. Observation of the catheter tubing revealed that it was draped over Resident # 104's thighs, then rose over the arm of the wheelchair and into the collection bag. On 07/28/21 at 1:30 p.m., an observation of Resident # 104 revealed they were sitting in their power wheelchair. Observation of the wheelchair revealed the catheter collection bag was hanging	F 550		

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F 550	Continued From page 3	F 550		

on the front of the control arm of power wheelchair. Further observation of the catheter collection bag revealed that it was at the height of Resident # 104's navel while they were sitting in their wheelchair. Observation of the catheter tubing revealed that it was draped over Resident # 104's thighs, then rose over the arm of the wheelchair and into the collection bag.

The POS [physician's order sheet] for Resident # 104 dated 07/28/2021 documented, "Urinary Catheter: Condom change PRN [as needed] if obstructed. Order Date: 07/28/2021."

The comprehensive care plan for Resident # 104 dated 07/05/2021 failed to evidence documentation to address Resident # 104's condom catheter.

On 07/27/21 at 12:50 p.m., an interview was conducted with Resident # 104. When asked who placed the catheter collection bag on the arm of the wheelchair Resident # 104 stated, "The nurse." When asked if he liked the catheter collection bag on the arm of the wheelchair Resident # 104 stated, "Not really."

On 07/28/2021 at 3:12 p.m. an interview was conducted with LPN [licensed practical nurse] # 3, unit manager. After being in informed of the above observations of Resident # 104's catheter collection bag hanging on the front of the control arm of power wheelchair, LPN # 3 stated, "That's a dignity issue."

The facility's policy "Resident's Rights In Nursing Homes" documented in part, "The resident has the right to a dignified existence, self-determination, choice, communication with,

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F 550	Continued From page 4 and access to persons and services inside and outside the facility." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. [2] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, it was	F 558	**F558:** **Reasonable Accommodations Needs/Preferences** 1. Residents #45 and #91 continue to reside in facility. Call bells for both Residents were immediately positioned within reach upon notification. 2. All residents have the potential to be affected by this alleged deficient practice. Audit conducted by nursing	

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F 558	Continued From page 5 determined that the facility staff failed to ensure accommodation of resident needs maintain for two of 49 residents, Resident #45 and Resident #91. The facility staff failed to ensure the call bells for Resident #45 and 91 were positioned and maintained within reach. The findings include: 1. Resident #45 was admitted to the facility with diagnoses that included but were not limited to atrial fibrillation (1) and myocardial infarction (2). Resident #45's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/4/2021, coded Resident #45 as scoring a 6 on the brief interview for mental status (BIMS) scale, 6- being severely impaired for making daily decisions. Section G coded Resident #45 as requiring extensive assistance of one staff member for toilet use and personal hygiene. Section G further documented Resident #45 not having any impairment in the upper extremities. The comprehensive care plan for Resident #45 dated 5/28/2021 documented in part, "At risk for falls due to impaired balance/poor coordination, involuntary movements. Date Initiated: 05/28/2021." Under "Interventions/Tasks" it documented in part, "...Have commonly used articles within easy reach..." On 7/27/2021 at approximately 11:43 a.m., an observation was made of Resident #45 in their room. Resident #45 was observed lying in bed with the call bell clipped on the top right corner of the mattress. The end of the call bell with the	F 558	management to verify the current residents had their call bells within reach. 3.DON or designee will educate facility staff that call bells for Residents must be positioned and maintained within reach. 4.DON or designee will audit 5 Residents call bell placement 3 times a week for 4 weeks and monthly times 2 to ensure call bells are positioned and maintained within reach. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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F 558	Continued From page 6 press button for resident use was observed hanging on the side of the bed at the top right corner of the bed frame. At this time, an interview was attempted with Resident #45. When asked if they could reach their call bell, Resident #45 stated, "I don't know." Additional observations on 7/27/2021 at 2:30 p.m. revealed the call bell located in the position as documented above. Observation of the call bell on 7/28/2021 at 8:35 a.m. revealed the call bell clipped to the sheet with the press button for resident use located beside Resident #45's right hand. On 7/28/2021 at approximately 11:15 a.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that the call bell should be clipped to the sheet or the residents clothing. CNA #5 stated that the purpose of this was to be within reach. CNA #5 stated that if the call light was placed at the top of the mattress the resident would not be able to reach it. On 7/28/2021 at approximately 11:18 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the call bell should be placed on the bed with the clip so it does not fall off. LPN #4 stated that the call bell placement was checked during rounds by CNA's and nurses. On 7/28/2021 at approximately 11:21 a.m., an interview was conducted with LPN #7. LPN #7 stated that the staff checked call bell placement each time they rounded on residents. LPN #7 stated that the call bell should be placed across their lap so it was accessible to the resident. LPN	F 558		

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F 558	Continued From page 7 #7 was informed of the call bell location for Resident #45 during observations conducted on 7/27/2021. LPN #7 stated that Resident #45 would not have been able to reach it in that location. On 7/28/2021 at approximately 5:45 p.m., a request was made to ASM (administrative staff member) #1, the regional director of clinical services for the facility policy on call bell placement. The facility policy, "Bedrooms" dated May 2017 documented in part, "All resident rooms are equipped with a resident call system that allows residents to call for staff assistance. Calls are directed to either a staff member or to a centralized work area..." On 7/28/2021 at approximately 5:30 p.m., ASM (administrative staff member) #1, the regional director of clinical services, ASM #2, the director of nursing, and ASM #4, the medical director were made aware of the above concern. No further information was presented prior to exit. References: 1. Atrial fibrillation A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html>. 2. Myocardial infarction Heart attack. Most heart attacks are caused by a blood clot that blocks one of the coronary	F 558		

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F 558	Continued From page 8 arteries. The coronary arteries bring blood and oxygen to the heart. If the blood flow is blocked, the heart is starved of oxygen and heart cells die. This information was obtained from the website: https://medlineplus.gov/ency/article/000195.htm. 2. Resident #91 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (1) and dementia (2). Resident #91's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/25/2021, coded Resident #91 as being severely impaired for making daily decisions. Section G coded Resident #91 as requiring extensive assistance of one staff member for toilet use and totally dependent of one staff member for personal hygiene. Section G further documented Resident #45 having an impairment in the upper extremities on one side. The comprehensive care plan for Resident #91 dated 5/26/2021 documented in part, "At risk for falls due to impaired balance/poor coordination, sensory deficit. Date Initiated: 05/26/2021." Under "Interventions/Tasks" it documented in part, "...Have commonly used articles within easy reach..." On 7/27/2021 at approximately 11:59 a.m., an observation was made of Resident #91 in their room. Resident #91 was observed lying in bed with the call bell located in the floor to the left side of the bed near the privacy curtain. At this time, an interview was attempted with Resident #91. When asked if they could reach their call bell, Resident #91 stated, "Yes." Resident #91 then began to search for the call bell beside them and	F 558		

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F 558	Continued From page 9 asked where it was. On 7/27/2021 at approximately 12:10 a.m., an observation was made of a staff member entering Resident #91's room to provide care. Additional observations on 7/27/2021 at 2:30 p.m. and 7/28/2021 at 8:37 a.m. revealed the call bell located in the floor to the left side of the bed near the privacy curtain. On 7/28/2021 at approximately 11:15 a.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that the call bell should be clipped to the sheet or the residents clothing. CNA #5 stated that the purpose of this was to be within reach. CNA #5 stated that the call bell should never be left in the floor. CNA #5 stated that at times the call bell may be dropped to the floor but they checked them during rounds and made sure they were in reach before they left the room. On 7/28/2021 at approximately 11:18 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that the call bell should be placed on the bed with the clip so it does not fall off. LPN #4 stated that the call bell placement was checked during rounds by CNA's and nurses. On 7/28/2021 at approximately 11:21 a.m., an interview was conducted with LPN #7. LPN #7 stated that the staff checked call bell placement each time they rounded on residents. LPN #7 stated that the call bell should be placed across their lap so it was accessible to the resident. LPN #7 was informed of the call bell location for Resident #91 during observations conducted on	F 558		

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F 558	Continued From page 10 7/27/2021 and 7/28/2021. LPN #7 stated that Resident #91 would not have been able to reach it on the floor. On 7/28/2021 at approximately 5:30 p.m., ASM (administrative staff member) #1, the regional director of clinical services, ASM #2, the director of nursing, and ASM #4, the medical director were made aware of the above concern. No further information was presented prior to exit. References: 1. Cerebrovascular disease, infarction or accident A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . 2. Dementia 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.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584	**F584: Reasonable Accommodations Needs/Preferences** 1. The windowsill in Room 122 was observed with peeling paint and large chips of paint peeled up on the surface. Windowsill paint was immediately	

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F 584	Continued From page 11 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility	F 584	corrected by Maintenance staff upon notification. 2.All rooms have the potential to be affected by this alleged deficient practice. An Audit was conducted by maintenance of residents' room for peeling and chipping of paint on the windowsills to assess need for repair. 3. Administrator will educate facility staff to report any areas of paint peeling or chipping to maintenance for repair. 4.Director of Maintenance or designee will audit 5 residents room windowsills for peeling or chipping paint weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

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F 584	Continued From page 12 staff failed to maintain a homelike environment in one of 126 resident rooms in the facility, (room 122). The window sill in resident room 122 was observed with peeling paint and large chips of paint peeled up on the surface. The findings include: On 7/27/2021 at approximately 11:40 a.m., an observation was made of resident rooms in the facility. In resident room 122, observation revealed a window over the heating/air conditioning unit on the wall. The sill of the window was approximately 48 inches wide and 12 inches deep. A flower pot was on the window sill. One-quarter of the surface of the window sill, was observed with large chipped areas of peeling paint exposing the sheetrock underneath. Four additional areas approximately six inches in size were observed on the window sill with cracked and peeling paint. The paint chips were raised up from the surface of the window sill. Additional observations on 7/27/2021 at 2:30 p.m. and 7/28/2021 11:15 a.m. revealed the findings as described above. On 7/28/2021 at approximately 11:15 a.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that any environmental concerns were reported to maintenance for repairs. CNA #5 stated that peeling paint was not homelike and should be reported to be repaired. CNA #5 stated that they called maintenance on the telephone and put in a work order when they found any concerns that needed repair. On 7/28/2021 at approximately 11:20 a.m., an	F 584		

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F 584	Continued From page 13 interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated that they notified maintenance of any environmental concerns by calling them or putting in work orders. LPN #7 stated that they worked on the hallway with the resident room in question frequently. LPN #7 observed the window sill in resident room 122 with the peeling paint and large paint chips exposing the sheetrock underneath and stated that it should have been reported to maintenance for repairs. On 7/28/2021 at approximately 1:30 p.m., an interview was conducted with OSM (other staff member) #7, the director of maintenance, housekeeping and laundry. OSM #7 stated that they were not aware of any repairs needed in resident room 122. OSM #7 observed the window sill in resident room 122 with peeling paint exposing the sheetrock underneath and stated that they would take care of it. OSM #7 stated that the window sill condition did not make the room homelike. On 7/28/2021 at approximately 5:45 p.m., a request was made to ASM (administrative staff member) #1, the regional director of clinical services for the facility policy on maintaining a homelike environment. The facility policy, "Quality of Life- Homelike Environment" dated May 2017 documented in part, "Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible..." The facility policy, "Bedrooms" dated May 2017 documented in part, "All residents are provided	F 584		

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F 584	Continued From page 14 with clean, comfortable and safe bedrooms that meet federal and state requirements..." On 7/28/2021 at approximately 5:30 p.m., ASM (administrative staff member) #1, the regional director of clinical services, ASM #2, the director of nursing, and ASM #4, the medical director were made aware of the above concern. No further information was presented prior to exit.	F 584		
F 622 SS=E	No further information was presented prior to exit. Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622	**F622: Transfer and Discharge Requirements** 1.Residents #101, #80, #15, #23, and #52 continue to reside in facility. Residents #83, and #114 continues to reside in facility. 2.All residents have the potential to be affected by this alleged deficient practice. Audit by nursing management conducted on residents from August 1st to verify that the transfer form and comprehensive care plan goals were sent with resident upon transfer to another health care institution. 3.DON or designee will educate nursing staff on ensuring that the transfer form and comprehensive care plan goals are sent with Resident's that are being transferred to another health care institution and communicated with the receiving health care institution and appropriate documentation in the EHR. 4.DON or designee will audit Residents that transfer to another health care institution have a transfer form,	

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F 622	Continued From page 15 resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or	F 622	comprehensive care plan goals sent, communicated, and documented in EHR weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021	

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F 622	Continued From page 16 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. 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 provide the required transfer or discharge documentation for seven of 49 residents in the survey sample, Residents #101, #83, #114, #80, #15, #23 and #52. The facility staff failed to ensure that comprehensive care plan goals for Residents #101, #83, #114, #80, #15, #23 and #52, were provided and communicated to the receiving health care institution upon transfer to the hospital. The findings include: 1. The facility staff failed to provide evidence that	F 622		

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F 622	Continued From page 17 all required information (comprehensive care plan goals) was provided to hospital staff when Resident #101 was transferred to the hospital on 6/15/21. Resident #101 was admitted to the facility on 5/18/07. Resident #101's diagnoses included but were not limited to multiple sclerosis (1), seizures and high blood pressure. Resident #101's quarterly minimum data set assessment with an assessment reference date of 7/6/21, coded the resident's cognitive skills for daily decision making as severely impaired. Review of Resident #101's clinical record revealed the resident was transferred to the hospital on 6/15/21 because the resident was blue in the face, foaming out of the mouth and presented with rapid labored breathing. Further review of Resident #101's clinical record, including nurses' notes and a transfer form dated 6/15/21, failed to reveal evidence that the facility staff provided the resident's comprehensive care plan goals to the receiving hospital staff. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she sends a transfer form, face sheet, list of medications, recent lab [laboratory tests] results and a list of diagnoses when residents are transferred to the hospital. LPN #4 stated she has never sent care plan goals to the hospital when residents are transferred. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern.	F 622		

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F 622	Continued From page 18 The facility policy titled, "Transfer or Discharge, Emergency" documented, "4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: d. Prepare a transfer form to send with the resident..." The policy did not specify the exact information that will be provided. No further information was presented prior to exit. Reference: (1) Multiple Sclerosis is a nervous system disease that affects the brain and spinal cord . This information was obtained from: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=ms&_ga=2.168269095.727485085.1627513122-1380714373.1627513122 2. The facility staff failed to provide the comprehensive care plan goals to the receiving hospital upon Resident #83's transfer to the hospital on 6/1/2021. Resident #83 was admitted to the facility on 5/3/2021 with a readmission on 6/17/2021, with diagnoses that included but were not limited to: urinary tract infection, stroke (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) (1), and cancer of the colon. The most recent MDS (minimum data set) assessment, a Medicare five day assessment,	F 622		

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F 622	Continued From page 19 with an assessment reference date of 6/24/2021, coded Resident #83 as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. Resident #83 was coded as requiring extensive assistance for most of his activities of daily living except eating in which he was coded as independent after set up assistance was provided. A nurse's note dated, 6/1/2021 at 11:11 a.m. documented, "The resident left the facility via non-emergency transportation with 2 attendants. He was alert and oriented. He was clean. No complaint of pain or discomfort. MD (medical doctor) and RP (responsible party) aware." Review of the clinical record failed to evidence the comprehensive care plan goals were sent with the resident upon transfer to the hospital on 6/1/2021. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she sends a transfer form, face sheet, list of medications, recent lab results and a list of diagnoses when residents are transferred to the hospital. LPN #4 stated she has never sent care plan goals to the hospital when residents are transferred. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m., regarding the documents sent with a resident transferred to the hospital. LPN #3 stated she sends the order summary, DNR (do not resuscitate), and face sheet." When asked if she sends the care plan goals with the resident, LPN #3 stated she has never sent the	F 622		

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F 622	Continued From page 20 care plan in all of her years. An interview was conducted with LPN #3 on 7/29/2021 at 09:10 a.m., regarding why Resident #83 was sent to the hospital. LPN #3 stated he had abnormal labs (laboratory) test results the day before, his WBC (white blood cell count) was 62.4 and his potassium was high. The doctor decided to transfer him that morning. It's my error that I didn't document the reason why he went to the hospital." ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 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 114. 3. The facility staff failed to provide the comprehensive care plan goals to the receiving hospital upon Resident #114's transfer to the hospital on 7/1-5/2021. Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general	F 622		

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F 622	Continued From page 21 term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat). (3) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, coded Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as limited assistance of one staff member for most of her activities of daily living. A nurse's note dated, 7/5/2021 at 8:42 a.m. documented, "Writer called into the resident room by the resident, who stated she needed to go to the hospital. She stated she felt full and wanted to get dialysis there. She also mentioned running for 3 hours versus 4 hours at the dialysis center. I informed the resident today was her dialysis day and we will try to up her chair time. Dialysis center contacted and the resident chair time was changed to 2:45 p.m. Writer back into the resident room with another team member. The resident was noted to have an acute change. She was noted to be laying on her right side in bed, eyes closed, lethargic, oxygen via nasal cannula at 4 liters going. VS (vital signs) T (temperature) 101; O2 sat (saturation) 89% on 4 liters, BP (blood pressure) 155/90, P (pulse) 77. MD (medical doctor) notified and 911 called, the resident left the facility, requesting to be transported to (initials of hospital). The resident was taken to (name of hospital) for respiratory	F 622		

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F 622	Continued From page 22 distress." Review of the clinical record failed to evidence the comprehensive care plan goals were sent with the resident upon transfer to the hospital. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m., regarding the documents sent with a resident transferred to the hospital. LPN #3 stated she sends the order summary, DNR (do not resuscitate), and face sheet." When asked if she sends the care plan goals with the resident, LPN #3 stated she has never sent the care plan in all of her years. ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 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 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 43. 4. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving facility for the Resident # 80's transfer to the hospital on 06/01/2021. Resident # 80 was admitted to the facility with	F 622		

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F 622	Continued From page 23 diagnoses included but were not limited to: heart disease and stroke. Resident # 80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Review of Resident #80's clinical record electronic and paper, revealed a nurse's note dated 06/01/2021 at 7:15 p.m., which documented in part, "Writer called to resident room by CNA [certified nursing assistant]. The resident was noted to be lying on the left side of his bed, on the floor, with a pillow under his head. The resident was last seen sitting up on the side of the bed, eating his dinner. His wheelchair was at the foot of the bed. The resident is alert and oriented. Writer went to do ROM [range of motion] assessment to assist the resident into bed. The resident refused, stating his lower back and neck hurt. This writer tried to talk with the resident and explain what I was going to do, the resident continue to refuse my assistance stating, 'I want to go to the hospital' 911 called and arrived to the facility. Upon entering the room, the resident was on the floor on his left side. He stated, 'he went to get in his wheelchair and it rolled from under him.' He complained to the EMTs [emergency medical technicians] his lower back was hurting. The resident left the facility with 4 [four] EMTs on a stretcher. The resident was alert and oriented. No protective equipment was noted. Report called to [Name of Hospital] ER and given to [Name of Hospital Staff Member]."	F 622		

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F 622	Continued From page 24 Review of the EHR [electronic health record] and the paper clinical record for Resident # 80 failed to evidence that the comprehensive care plan goals were sent to the receiving facility at the time of Resident # 80's hospital transfer. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN [licensed practical nurse] #4 regarding documentation sent for a resident transfer. LPN #4 stated she sends a transfer form, face sheet, list of medications, recent lab results and a list of diagnoses when residents are transferred to the hospital. LPN #4 stated she has never sent care plan goals to the hospital when residents are transferred. On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. 5. The facility staff failed to evidence that the comprehensive care plan goals were provided to the receiving facility for a facility-initiated hospital transfer of Resident # 15, on 05/18/2021. Resident # 15 was admitted to the facility with diagnoses that included but were not limited to: altered mental status, and diabetes mellitus [1]. Resident # 15's most recent MDS [minimum data set], a quarterly assessment with an ARD (assessment reference date) of 05/01/2021, coded Resident # 15 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.	F 622		

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F 622	Continued From page 25 The nurse's note for Resident # 15 dated 05/18/2021 at 5:06 p.m., documented, "Writer received a call from [Name of Nurse Practitioner], stating MD [medical doctor], [Name of Medical Doctor] would like for the resident to be sent to the ER [emergency room] via [by] 911 due to elevated sodium of 160. The resident RP [responsible party] was called. She stated she had spoken with the MD and is in agreement with the MD. She would like for her mom to be sent out. 911 called." Review of the EHR [electronic health record] and the paper clinical record for Resident # 15 failed to evidence that the comprehensive care plan goals were sent to the receiving facility at the time of Resident # 15's facility-initiated transfer. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN [licensed practical nurse] #4 regarding documentation sent for a resident transfer. LPN #4 stated she sends a transfer form, face sheet, list of medications, recent lab results and a list of diagnoses when residents are transferred to the hospital. LPN #4 stated she has never sent care plan goals to the hospital when residents are transferred. On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A chronic disease in which the body cannot	F 622		

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regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm.

6. The facility staff failed to evidence what, if any, documentation was provided to the receiving facility upon transfer of Resident #23 to the hospital on 5/21/21.

Resident #23 was admitted to the facility on 1/10/20, discharged to home on 6/1/21 and readmitted to the facility on 7/13/21. The resident had the diagnoses of but not limited to a stroke, quadriplegia, aphasia, diabetes, anxiety, high blood pressure, COVID-19, and contractures. The admission / 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/21 coded the resident as moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living.

A review of the clinical record revealed a nurse's note dated 5/21/21 that documented, "called to resident room by nursing staff, resident noted with respiratory distress, blue tinge color to skin, cpr (cardio pulmonary resuscitation) initiated, 911 called, MD (medical doctor) called, rp (responsible party) notified. Resident (Sic.) suctioned several times, respirations returned to normal, vital signs within normal limits at the time emt's (emergency medical technician) arrived to facility. resident is at baseline, emt's decided on taking resident to er (emergency room) for

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F 622	Continued From page 27 evaluations, rp will meet resident at er (emergency room)." The resident was readmitted to the facility on 5/26/21. A physician's progress note dated 5/26/21 documented, "(Resident #23) is a 69-year-old female with significant past medical history. Patient was sent to ED (emergency department) d/t (due to) respiratory distress. Resident was admitted to (name of hospital) for aspiration into airway, found to have a UTI (urinary tract infection) w/ (with) E. Coli (Escherichia coli) and treated with IV (intravenous) ABT (antibiotic therapy), stabilized, discharged, and returned to (facility)..." Further review of the clinical record failed to reveal any evidence of what, if any, documentation was provided to the receiving facility, including, but not limited to: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals (F) All other necessary information, including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she sends a transfer form, face sheet, list of medications, recent lab (laboratory	F 622		

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tests) results and a list of diagnoses when residents are transferred to the hospital. LPN #4 stated she has never sent care plan goals to the hospital when residents are transferred.

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m. When asked if a resident goes to the hospital, was documents go with the resident, LPN #3 stated she sends the order summary, DNR (do not resuscitate), and facesheet." When asked if she sends the care plan goals with the resident, LPN #3 stated she has never sent the care plan in all of her years.

On 7/28/21 at 10:40 AM the facility was provided with a list that included a request for evidence of what documents were sent to the hospital when Resident #23 was transferred to the hospital on 5/21/21 Nothing was provided by the end of the survey.

On 7/29/21 at 8:45 AM, the director of clinical services, , Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey.

7. The facility staff failed to evidence that comprehensive care plan goals were provided to the receiving facility upon transfer of Resident #52 to the hospital on 5/24/21.

Resident #52 was most recently readmitted to the facility on 6/4/21 with the diagnoses of but not limited to sepsis, diabetes, stroke, dysphasia, dysphagia, insomnia, seizures, high blood

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pressure, end stage renal disease, pacemaker, and COVID-19. The most recent MDS (Minimum Data Set) was a quarterly / 5-day assessment with an ARD (Assessment Reference Date) of 6/9/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for hygiene, toileting, dressing, and transfers; and supervision for eating.

A review of the clinical record revealed the following nurses notes:

5/24/21 at 2:42 PM: "Change of condition noted, resident c/o (complain of) being lightheaded, dizziness, BP 98/57 (blood pressure), MD (medical doctor) aware, okay to send him to dialysis, dialysis center aware before arrival, POA (power of attorney) aware, agree with care plan."

5/24/21 at 5:35 PM: "Assessed patient. Vital signs 91/53 (blood pressure) pulse 81 Temperature 100.7 96% (oxygen saturation) on RA (room air). Patient was given Tylenol (1). Patient was alert to self with confusion. Patient was assisted to room with girlfriend at bedside. RP (responsible party) and NP (nurse practitioner) were made aware of patients conditions."

5/24/21 at 8:15 PM: "MD (medical doctor) notified of resident low B/P (blood pressure), elevated temp (temperature), low O2 (oxygen) level. Writer place resident on O2 AT 2 LNC (two liters nasal cannula). RP (responsible party) notified of change in condition and MD order to transfer to ED (emergency department) (name of

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F 622	Continued From page 30 hospital) for observation." A physician's progress note dated 6/6/21 documented, "....was recently admitted to the hospital after his dialysis session since his blood pressure was running very low and he had a temperature of 100.3 and oxygen saturation was 83. ..evaluation in the hospital led to diagnosis of sepsis from line infection... He was also diagnosed with infective endocarditis... He will be continuing IV (intravenous) cefazolin (2) 3 times per week for 3 weeks during dialysis sessions. Recent repeat blood cultures dated 5/29/2021 were negative. Infectious disease is following closely... " Further review failed to reveal any evidence that the comprehensive care plan goals were sent to the receiving facility upon transfer. The "SNF / NF to Hospital Transfer Form" dated 5/24/21 was reviewed. This form documented resident demographic information, contact information, allergies, code status, functional status, treatments, precautions, and immunizations. However, there was no documentation that the comprehensive care plan goals were provided to the receiving hospital. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she sends a transfer form, face sheet, list of medications, recent lab results and a list of diagnoses when residents are transferred to the hospital. LPN #4 stated she has never sent care plan goals to the hospital when residents are transferred. An interview was conducted with LPN (licensed	F 622		

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F 622	Continued From page 31 practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m. When asked if a resident goes to the hospital, was documents go with the resident, LPN #3 stated she sends the order summary, DNR (do not resuscitate), and facesheet." When asked if she sends the care plan goals with the resident, LPN #3 stated she has never sent the care plan in all of her years. On 7/28/21 at 10:40 AM the facility was provided with a list that included a request for evidence of what documents were sent to the hospital when Resident #52 was transferred on 5/24/21. Nothing identifying that comprehensive care plan goals were provided to the receiving hospital on 5/25/21 was provided. On 7/29/21 at 8:45 AM, the director of clinical services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey. (1) Tylenol - is used to treat mild to moderate pain and fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html (2) Cefazolin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a682731.html	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		

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F 623	Continued From page 32 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623	**F623: Notice Requirements Before Transfer/Discharge** 1.Residents #101, #15, #23, and #52 continue to reside in facility. Residents #83 and #114 have discharged from the facility. 2.All residents have the potential to be affected by this alleged deficient practice. Audit was conducted by Social Service on resident discharged since 8/1/2021 have notification to the Ombudsman, resident and RP. 3.Administrator or designee will educate nursing staff, social workers, and admissions team that any resident that is transferred and discharged from the facility must have a notification in writing to the Ombudsman, Resident and RP. 4.Social Service or designee will audit transfers and/or discharges weekly times 4 weeks and monthly times 2 to ensure that written notification of the transfers/dischargers were provided to the Ombudsman, Resident and/or RP. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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F 623	Continued From page 33 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

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F 623	Continued From page 34 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide written notification of transfer to the resident and/or their representative for six of 49 residents in the survey sample, Residents #101, #83, #114, #15, #23 and #52. The findings include: 1. Resident #101 was transferred to the hospital on 6/15/21. The facility staff failed to provide written notification of the transfer to Resident #101's representative. Resident #101 was admitted to the facility on 5/18/07. Resident #101's diagnoses included but were not limited to multiple sclerosis, seizures and high blood pressure. Resident #101's quarterly minimum data set assessment with an assessment reference date of 7/6/21, coded the	F 623		

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F 623	Continued From page 35 resident's cognitive skills for daily decision making as severely impaired. Review of Resident #101's clinical record revealed the resident was transferred to the hospital on 6/15/21 because the resident was blue in the face, foaming out of the mouth and presented with rapid labored breathing. Further review of Resident #101's clinical record, including nurses' notes and a transfer form dated 6/15/21, revealed the resident's representative was notified of the transfer but failed to reveal that written notification of the transfer was provided to Resident #101's representative. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she provides representatives with verbal notice of resident transfers to the hospital but does not provide written notice of the transfers. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Transfer or Discharge, Emergency" documented, "4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures: e. Notify the representative (sponsor) or other family member..." No further information was presented prior to exit. Reference: (1) Multiple Sclerosis is a nervous system	F 623		

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F 623	Continued From page 36 disease that affects the brain and spinal cord . This information was obtained from: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=ms&_ga=2.168269095.727485085.1627513122-1380714373.1627513122 2. The facility staff failed to provide a written notification to Resident #83 and/or the responsible party for the reason the resident was sent to the hospital. Resident #83 was admitted to the facility on 5/3/2021 with a readmission on 6/17/2021, with diagnoses that included but were not limited to: urinary tract infection, stroke (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) (1), and cancer of the colon. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 6/24/2021, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living except eating in which he was independent after set up assistance was provided. The nurse's note dated, 6/1/2021 at 11:11 a.m. documented, "The resident left the facility via non-emergency transportation with 2 attendants. He was alert and oriented. He was clean. No	F 623		

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F 623	Continued From page 37 complaint of pain or discomfort. MD (medical doctor) and RP (responsible party) aware." Review of the clinical record failed to evidence that a written notification of the reason the resident was transferred to the hospital was provided to the resident and/or responsible party for the hospital transfer on 6/1/2021. An interview was conducted with LPN (licensed practical nurse) #6 on 7/28/2021 at 12:17 p.m. When asked if they ever provide the resident and/or the responsible party something in writing as to the reason the resident was transferred to the hospital, LPN #6 stated, "That's not on nursing, maybe social services does that but nursing does not do that." An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m., regarding providing the resident or the responsible party a written notification as to why the resident is being transferred to the hospital. LPN #3 stated they verbally inform the resident and/or their responsible party but don't give them anything in writing. ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 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 114.	F 623		

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F 623	Continued From page 38 3. The facility staff failed to provide a written notification to Resident #114 and/or the responsible party for the reason the resident was sent to the hospital. Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat). (3) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, coded Resident #114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as limited assistance of one staff member for most of her activities of daily living. A nurse's note dated, 7/5/2021 at 8:42 a.m. documented, "Writer called into the resident room by the resident, who stated she needed to go to the hospital. She stated she felt full and wanted to get dialysis there. She also mentioned running	F 623		

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F 623	Continued From page 39 for 3 hours versus 4 hours at the dialysis center. I informed the resident today was her dialysis day and we will try to up her chair time. Dialysis center contacted and the resident chair time was changed to 2:45 p.m. Writer back into the resident room with another team member. The resident was noted to have an acute change. She was noted to be laying on her right side in bed, eyes closed, lethargic, oxygen via nasal cannula at 4 liters going. VS (vital signs) T (temperature) 101; O2 sat (saturation) 89% on 4 liters, BP (blood pressure) 155/90, P (pulse) 77. MD (medical doctor) notified and 911 called, the resident left the facility, requesting to be transported to (initials of hospital). The resident was taken to (name of hospital) for respiratory distress." Review of the clinical record failed to evidence that a written notification of the reason the resident was transferred to the hospital was provided to the resident and/or responsible party for the hospital transfer on 7/5/2021. An interview was conducted with LPN (licensed practical nurse) #6 on 7/28/2021 at 12:17 p.m. When asked if they ever provide the resident and/or the responsible party something in writing as to the reason the resident was transferred to the hospital, LPN #6 stated, "That's not on nursing, maybe social services does that but nursing does not do that." An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m., regarding providing the resident or the responsible party a written notification as to why the resident is being transferred to the hospital. LPN #3 stated they	F 623		

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F 623	Continued From page 40 verbally inform the resident and/or their responsible party but don't give them anything in writing. ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 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 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 43. 4. The facility staff failed to provide Resident # 15 and Resident # 15's representative written notification of a facility-initiated transfer of Resident #15 on 05/18/2021. Resident # 15 was admitted to the facility with diagnoses that included but were not limited to: altered mental status, and diabetes mellitus [1]. Resident # 15's most recent MDS [minimum data set], a quarterly assessment with an ARD (assessment reference date) of 05/01/2021, coded Resident # 15 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. A nurse's note for Resident # 15 dated 05/18/2021 at 5:06 p.m., documented, "Writer	F 623		

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F 623	Continued From page 41 received a call from [Name of Nurse Practitioner], stating MD [medical doctor], [Name of Medical Doctor] would like for the resident to be sent to the ER [emergency room] via [by] 911 due to elevated sodium of 160. The resident RP [responsible party] was called. She stated she had spoken with the MD and is in agreement with the MD. She would like for her mom to be sent out. 911 called." Review of the clinical record and the EHR (electronic health record) for Resident # 15 failed to evidence that a written notification of discharge was provided to the resident and resident's representative for the facility-initiated transfer on 05/18/2021 for Resident # 15. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4 regarding written notification to the resident and the resident's representative. LPN #4 stated she provides representatives with verbal notice of resident transfers to the hospital but does not provide written notice of the transfers. On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way	F 623		

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F 623	Continued From page 42 to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. 5. The facility staff failed to evidence that a written notice of a hospital transfer was provided to the responsible party upon Resident #23's transfer to the hospital on 5/21/21. Resident #23 was admitted to the facility on 1/10/20, discharged to home on 6/1/21 and readmitted to the facility on 7/13/21. The resident had the diagnoses of but not limited to a stroke, quadriplegia, aphasia, diabetes, anxiety, high blood pressure, COVID-19, and contractures. The admission / 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/21 coded the resident as moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 5/21/21 that documented, "called to resident room by nursing staff, resident noted with respiratory distress, blue tinge color to skin, cpr (cardio pulmonary resuscitation) initiated, 911 called, MD (medical doctor) called, rp (responsible party) notified. resident suctioned several times, respirations returned to normal, vital signs within normal limits at the time emt's (emergency medical technician) arrived to facility. resident is at baseline, emt's decided on taking resident to er (emergency room) for evaluations, rp will meet resident at er (emergency room)." The resident was readmitted to the facility on 5/26/21.	F 623		

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F 623	Continued From page 43	F 623		

A physician's progress note dated 5/26/21 documented, "(Resident #23) is a 69-year-old female with significant past medical history. Patient was sent to ED (emergency department) d/t (due to) respiratory distress. Resident was admitted to (name of hospital) for aspiration into airway, found to have a UTI (urinary tract infection) w/ (with) E. Coli (Escherichia coli) and treated with IV (intravenous) ABT (antibiotic therapy), stabilized, discharged, and returned to (facility)..."

Further review of the clinical record failed to reveal any evidence that a written notification of a hospital transfer was provided to the RP (responsible party) upon transfer of Resident #23 to the hospital on 5/21/21.

On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she provides representatives with verbal notice of resident transfers to the hospital but does not provide written notice of the transfers.

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager,on 7/28/2021 at 2:28 p.m. When asked if she provides the resident or the responsible party a written notification as to why the resident is being transferred to the hospital, LPN #3 stated they verbally inform the resident and/or their responsible party but don't give them anything in writing.

On 7/28/21 at 10:40 AM the facility was provided with a list that included a request for evidence of written notificaiton to the RP of the hospital transfer when the resident was transferred on

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F 623	Continued From page 44 5/21/21. Nothing was provided. On 7/29/21 at 8:45 AM, the Administrator, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey. 6. The facility staff failed to evidence that a written notice of a hospital transfer was provided to the responsible party upon a hospital transfer on 5/24/21 for Resident #52. Resident #52 was most recently readmitted to the facility on 6/4/21 with the diagnoses of but not limited to sepsis, diabetes, stroke, dysphasia, dysphagia, insomnia, seizures, high blood pressure, end stage renal disease, pacemaker, and COVID-19. The most recent MDS (Minimum Data Set) was a quarterly / 5-day assessment with an ARD (Assessment Reference Date) of 6/9/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for hygiene, toileting, dressing, and transfers; and supervision for eating. A review of the clinical record revealed the following nurses notes: 5/24/21 at 2:42 PM: "Change of condition noted, resident c/o (complain of) being lightheaded, dizziness, BP 98/57 (blood pressure), MD (medical doctor) aware, okay to send him to dialysis, dialysis center aware before arrival, POA (power of attorney) aware, agree with care plan."	F 623		

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F 623	Continued From page 45 5/24/21 at 5:35 PM: "Assessed patient. Vital signs 91/53 (blood pressure) pulse 81 Temperature 100.7 96% on RA (room air). Patient was given Tylenol (1). Patient was alert to self with confusion. Patient was assisted to room with girlfriend at bedside. RP (responsible party) and NP (nurse practitioner) were made aware of patients conditions." 5/24/21 at 8:15 PM: "MD (medical doctor) notified of resident low B/P (blood pressure), elevated temp, low O2 (oxygen) level. Writer place resident on O2 AT 2 LNC (two liters nasal cannula). RP (responsible party) notified of change in condition and MD order to transfer to ED (emergency department) (name of hospital) for observation." A physician's progress note dated 6/6/21 documented, "....was recently admitted to the hospital after his dialysis session since his blood pressure was running very low and he had a temperature of 100.3 and oxygen saturation was 83. ..evaluation in the hospital led to diagnosis of sepsis from line infection.. He was also diagnosed with infective endocarditis.. He will be continuing IV cefazolin (2) 3 times per week for 3 weeks during dialysis sessions. Recent repeat blood cultures dated 5/29/2021 were negative. Infectious disease is following closely..." Further review of the clinical record failed to reveal any evidence that a written notification of a hospital transfer was provided to the RP (responsible party) upon transfer to the hospital on 5/24/21. A review of the "SNF / NF to Hospital Transfer	F 623		

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F 623	Continued From page 46 Form" dated 5/24/21 was reviewed. This form documented resident demographic information, contact information, allergies, code status, functional status, treatments, precautions, and immunizations. However, there was no documentatition that a written notification of a hospital transfer was provided to the RP. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she provides representatives with verbal notice of resident transfers to the hospital but does not provide written notice of the transfers. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager,on 7/28/2021 at 2:28 p.m. When asked if she give the resident or the responsible party a written notification as to why the resident is being transferred to the hospital, LPN #3 stated they verbally inform the resident and/or their responsible party but don't give them anything in writing. On 7/28/21 at 10:40 AM the facility was provided with a list that included a request for evidence of written notificaiton to the RP of the hospital transfer when the resident was transferred on 5/24/21. None was ever provided. On 7/29/21 at 8:45 AM, the Administrator, Director of Nursing and Medical Director (Administrative Staff Member #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey.	F 623		

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F 623	Continued From page 47 (1) Tylenol - is used to treat mild to moderate pain and fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html (2) Cefazolin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a682731.html	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625	**F625: Notice of Bed Hold Policy Before/Upon Transfer** 1.Residents #80, #15, #23, and #52 continue to reside in facility. Residents #83 and #114 have discharged from the facility. 2.All residents have the potential to be affected by this alleged deficient practice. Audit by Admissions on residents transferred and currently in the hospital will be conducted to verify if resident received Notice of Bed Hold Policy 3.Administrator or designee will educate nursing, social workers, and admissions staff that any resident that is transferred from the facility must be provided bed hold notification to the Resident and/or RP. 4.Admission staff or designee will audit transfers and/or discharges weekly times 4 weeks and monthly times 2 to ensure that any Resident that is transferred from the facility is provided	

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F 625	Continued From page 48 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a notice of bed hold prior to and or upon transfer for six of 49 residents in the survey sample, # 83, #114, #80, #15, #23 and #52. The findings include: 1. The facility staff failed to provide Resident #83 and/or responsible party with a bed hold notification prior to and or upon a transfer to the hospital on 6/1/2021. Resident #83 was admitted to the facility on 5/3/2021 with a readmission on 6/17/2021, with diagnoses that included but were not limited to: urinary tract infection, stroke (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) (1), and cancer of the colon. The most recent MDS (minimum data set) assessment, a Medicare five day assessment, with an assessment reference date of 6/24/2021, coded Resident #83 as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance for most of his activities of daily living except eating in which he	F 625	bed hold notification to the Resident and/or RP. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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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
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was independent after set up assistance was provided.

The nurse's note dated, 6/1/2021 at 11:11 a.m. documented, "The resident left the facility via non-emergency transportation with 2 attendants. He was alert and oriented. He was clean. No complaint of pain or discomfort. MD (medical doctor) and RP (responsible party) aware."

Review of the clinical record failed to evidence a bed hold notice was provided to the resident and/or responsible party prior to and or upon transfer to the hospital on 6/1/2021.

On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses send the bed hold policy with residents when they are transferred to the hospital but they do not document evidence that this is done.

An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m. When asked if they provide the resident or responsible party notice of the bed hold policy, LPN #3 stated if the resident is unable to talk about it, she reaches out to the responsible party to see if they want to hold the bed. When asked where staff document this information, LPN #3 stated it should be documented in the nurse's note.

The facility policy, "Transfer or Discharge, Emergency" failed to evidence documentation related to the bed hold policy.

The facility policy, "Bed-Holds and Returns" documented in part, "3. Prior to a transfer, written

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information will be given to the resident and the resident representatives that explains in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed (non-Medicaid residents) or to hold a bed beyond the state bed=hold period (Medicaid residents); d. The details of the transfer (per the Notice of Transfer)."

ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 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 114.

2. The facility staff failed to provide Resident #114 and/or the responsible party with a bed hold notification upon transfer to the hospital on 7/2/2021.

Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and

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F 625	Continued From page 51 chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat). (3) The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, coded Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as limited assistance of one staff member for most of her activities of daily living. A nurse's note dated, 7/5/2021 at 8:42 a.m. documented, "Writer called into the resident room by the resident, who stated she needed to go to the hospital. She stated she felt full and wanted to get dialysis there. She also mentioned running for 3 hours versus 4 hours at the dialysis center. I informed the resident today was her dialysis day and we will try to up her chair time. Dialysis center contacted and the resident chair time was changed to 2:45 p.m. Writer back into the resident room with another team member. The resident was noted to have an acute change. She was noted to be laying on her right side in bed, eyes closed, lethargic, oxygen via nasal cannula at 4 liters going. VS (vital signs) T (temperature) 101; O2 sat (saturation) 89% (percent) on 4 liters, BP (blood pressure) 155/90, P (pulse) 77. MD (medical doctor) notified and 911 called, the resident left the facility, requesting to be transported to (initials of hospital). The resident was taken to (name of hospital) for respiratory distress."	F 625		

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F 625	Continued From page 52 Review of the clinical record failed to evidence a bed hold notice was provided to Resident #114 and/or the responsible party prior to and or upon transfer to the hospital on 7/5/2021. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses send the bed hold policy with residents when they are transferred to the hospital but they do not document evidence that this is done. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m. When asked if they provide the resident or responsible party notice of the bed hold policy, LPN #3 stated if the resident is unable to talk about it, she reaches out to the responsible party to see if they want to hold the bed. When asked where staff document this information, LPN #3 stated it should be documented in the nurse's note. ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 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 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and	F 625		

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F 625	Continued From page 53 Chapman, page 43. 3. The facility staff failed to provide or send a copy of the bed hold policy to the hospital with Resident #80 at the time of transfer on 06/01/2021. Resident # 80 was admitted to the facility with diagnoses included but were not limited to: heart disease and stroke. Resident # 80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. A nurse's note for Resident # 80 dated 06/01/2021 at 7:15 p.m., documented, "Writer called to resident room by CNA [certified nursing assistant]. The resident was noted to be lying on the left side of his bed, on the floor, with a pillow under his head. The resident was last seen sitting up on the side of the bed, eating his dinner. His wheelchair was at the foot of the bed. The resident is alert and oriented. Writer went to do ROM [range of motion] assessment to assist the resident into bed. The resident refused, stating his lower back and neck hurt. This writer tried to talk with the resident and explain what I was going to do, the resident continue to refuse my assistance stating, 'I want to go to the hospital' 911 called and arrived to the facility. Upon entering the room, the resident was on the floor on his left side. He stated, 'he went to get in his wheelchair and it rolled from under him.' He complained to the EMTs [emergency medical technicians] his lower back was hurting. The resident left the facility with 4 [four] EMTs on a	F 625		

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stretcher. The resident was alert and oriented. No protective equipment was noted. Report called to [Name of Hospital] ER and given to [Name of Hospital Staff Member]."

Review of the EHR [electronic health record] and the paper clinical record for Resident # 80 failed to evidence documentation that a bed hold policy was provided to Resident # 80 or Resident # 80's responsible party in regard to the transfer to the hospital on .

On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses send the bed hold policy with residents when they are transferred to the hospital but they do not document evidence that this is done.

On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern.

No further information was presented prior to exit.

4. The facility staff failed to provide or send a copy of the bed hold policy to the hospital with Resident # 15 at the time of transfer on 05/18/2021.

Resident # 15 was admitted to the facility with diagnoses that included but were not limited to: altered mental status, and diabetes mellitus [1].

Resident # 15's most recent MDS [minimum data set], a quarterly assessment with an ARD (assessment reference date) of 05/01/2021,

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F 625	Continued From page 55 coded Resident # 15 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. The nurse's note for Resident # 15 dated 05/18/2021 at 5:06 p.m., documented, "Writer received a call from [Name of Nurse Practitioner] , stating MD [medical doctor], [Name of Medical Doctor] would like for the resident to be sent to the ER [emergency room] via [by] 911 due to elevated sodium of 160. The resident RP [responsible party] was called. She stated she had spoken with the MD and is in agreement with the MD. She would like for her mom to be sent out. 911 called." Review of the EHR [electronic health record] and the paper clinical record for Resident # 15 failed to evidence documentation that a bed hold policy was provided to Resident # 15 or Resident # 15's responsible party in regard to the transfer to the hospital on 05/18/2021. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses send the bed hold policy with residents when they are transferred to the hospital but they do not document evidence that this is done. On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, regional director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit.	F 625		

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F 625	Continued From page 56 References: [1] A chronic disease in which the body cannot regulate the amount of sugar in the blood. The goal of treatment at first is to lower your high blood glucose level. Long-term goals are to prevent complications. The most important way to treat and manage type 2 diabetes is by being active and eating healthy foods. This information was obtained from the website: https://medlineplus.gov/ency/article/000313.htm. 5. The facility staff failed to evidence that a written bed hold notice was provided to the responsible party upon transfer of Resident #23 to the hospital on 5/21/21. Resident #23 was admitted to the facility on 1/10/20, discharged to home on 6/1/21 and readmitted to the facility on 7/13/21. The resident had the diagnoses of but not limited to a stroke, quadriplegia, aphasia, diabetes, anxiety, high blood pressure, COVID-19, and contractures. The admission / 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/21 coded the resident as moderately impaired in ability to make daily life decisions. The resident was coded as requiring total care for all areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 5/21/21 that documented, "called to resident room by nursing staff, resident noted with respiratory distress, blue tinge color to skin, cpr (cardio pulmonary resuscitation) initiated, 911 called, MD (medical doctor) called, rp (responsible party) notified. resident (Sic.) suctioned several times, respirations returned to normal, vital signs within normal limits at the time emt's (emergency medical technician) arrived to	F 625		

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F 625	Continued From page 57 facility. resident is at baseline, emt's decided on taking resident to er (emergency room) for evaluations, rp will meet resident at er (emergency room)." The resident was readmitted to the facility on 5/26/21. A physician's progress note dated 5/26/21 documented, "(Resident #23) is a 69-year-old female with significant past medical history. Patient was sent to ED (emergency department) d/t (due to) respiratory distress. Resident was admitted to (name of hospital) for aspiration into airway, found to have a UTI (urinary tract infection) w/ (with) E. Coli (Escherichia coli) and treated with IV (intravenous) ABT (antibiotic therapy), stabilized, discharged, and returned to (facility)..." Further review of the clinical record failed to reveal any evidence that a written bed hold notice was provided to the RP (responsible party) upon transfer of Resident #23 to the hospital on 5/21/21. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses send the bed hold policy with residents when they are transferred to the hospital but they do not document evidence that this is done. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m. When asked if they provide the resident or responsible party notice of the bed hold policy, LPN #3 stated if the resident is unable to talk about it, she reaches out to the	F 625		

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F 625	Continued From page 58 responsible party to see if they want to hold the bed. When asked where that is documented, LPN #3 stated it should be documented in the nurse's note. On 7/28/21 at 10:40 AM the facility was provided with a list that included a request for evidence of a written bed hold notice being provided to the RP upon transfer of Resident #23 to the hospital on 5/21/21. Nothing was provided. On 7/29/21 at 8:45 AM, the Director of Clinical Services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey. 6. The facility staff failed to evidence that a written bed hold notice was provided to the responsible party upon transfer of Resident #52 to the hospital on 5/24/21 for Resident #52. Resident #52 was most recently readmitted to the facility on 6/4/21 with the diagnoses of but not limited to sepsis, diabetes, stroke, dysphasia, dysphagia, insomnia, seizures, high blood pressure, end stage renal disease, pacemaker, and COVID-19. The most recent MDS (Minimum Data Set) was a quarterly / 5-day assessment with an ARD (Assessment Reference Date) of 6/9/21. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for hygiene, toileting, dressing, and transfers; and supervision for eating.	F 625		

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F 625	Continued From page 59 A review of the clinical record revealed the following nurses notes: 5/24/21 at 2:42 PM: "Change of condition noted, resident c/o (complain of) being lightheaded, dizziness, BP 98/57 (blood pressure), MD (medical doctor) aware, okay to send him to dialysis, dialysis center aware before arrival, POA (power of attorney) aware, agree with care plan." 5/24/21 at 5:35 PM: "Assessed patient. Vital signs 91/53 (blood pressure) pulse 81 Temperature 100.7 96% on RA (room air). Patient was given Tylenol (1). Patient was alert to self with confusion. Patient was assisted to room with girlfriend at bedside. RP (responsible party) and NP (nurse practitioner) were made aware of patients conditions." 5/24/21 at 8:15 PM: "MD (medical doctor) notified of resident low B/P (blood pressure), elevated temp, low O2 (oxygen) level. Writer place resident on O2 AT 2 LNC (two liters nasal cannula). RP (responsible party) notified of change in condition and MD order to transfer to ED (emergency department) (name of hospital) for observation." A physician's progress note dated 6/6/21 documented, "....was recently admitted to the hospital after his dialysis session since his blood pressure was running very low and he had a temperature of 100.3 and oxygen saturation was 83. ..evaluation in the hospital led to diagnosis of sepsis from line infection... He was also diagnosed with infective endocarditis... He will be continuing IV cefazolin (2) 3 times per week for 3 weeks during dialysis sessions. Recent repeat blood cultures dated 5/29/2021 were negative.	F 625		

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F 625	Continued From page 60 Infectious disease is following closely... " Further review of the clinical record failed to reveal any evidence that a written bed hold notice was provided to the RP (responsible party) upon transfer of Resident #52 to the hospital on 5/24/21. A review of the "SNF / NF to Hospital Transfer Form" dated 5/24/21 was reviewed. This form documented resident demographic information, contact information, allergies, code status, functional status, treatments, precautions, and immunizations. However, there was no documentation that a written bed hold notice was provided to the RP. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated the nurses send the bed hold policy with residents when they are transferred to the hospital but they do not document evidence that this is done. An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:28 p.m. When asked if they provide the resident or responsible party notice of the bed hold policy, LPN #3 stated if the resident is unable to talk about it, she reaches out to the responsible party to see if they want to hold the bed. When asked where that is documented, LPN #3 stated it should be documented in the nurse's note. On 7/28/21 at 10:40 AM the facility was provided with a list that included a request for evidence of a written bed hold notice being provided to the RP upon the hospital transfer when the resident was	F 625		

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F 625	Continued From page 61 transferred on 5/24/21. Nothing was provided. On 7/29/21 at 8:45 AM, the Regional Director of Clinical Services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey. (1) Tylenol - is used to treat mild to moderate pain and fever. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html (2) Cefazolin - is an antibiotic. Information obtained from https://medlineplus.gov/druginfo/meds/a682731.html	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure the assessment accurately reflected the status of one of 49 sampled residents, (Resident #104). The facility staff failed to accurately code Resident # 104's bladder status on the admission assessment MDS (minimum data set) with an ARD (assessment reference date) of 07/08/2021.	F 641	**F641: Accuracy of Assessments** 1.Residents #104 continues to reside in facility. 2.All residents have the potential to be affected by this alleged deficient practice. Audit on current residents by MDS staff to verify accuracy of coding for foley catheters and bowel and bladder coded accurately 3.Regional Director MDS or designee will educate MDS staff on completing accurate assessments to include but not limited to any Foley Catheters (internal and external) along with Bowel and	

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F 641	Continued From page 62 The findings include: Resident # 104 was admitted to the facility with diagnoses that included but were not limited to: Parkinson's disease [1] and multiple sclerosis [2]. Resident # 104's most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 07/08/2021, coded Resident # 104 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Resident # 18 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section H "Bladder and Bowel" Resident # 104 was coded under "H0100" as having an indwelling catheter and an external catheter. Under section H0300 "Urinary Incontinence" Resident # 104 was coded a number 1 [one] - "Occasionally incontinent (less than 7 [seven] episodes of incontinence)." The POS [physician's order sheet] for Resident # 104 dated 07/28/2021 documented, "Urinary Catheter: Condom change PRN [as needed] if obstructed. Order Date: 07/28/2021." The comprehensive care plan for Resident # 104 dated 07/05/2021 failed to evidence documentation to address Resident # 104's condom catheter. On 07/28/2021 at 1:30 p.m., an interview was conducted with LPN [Licensed practical nurse] # 5, MDS coordinator. After reviewing Resident # 104's admission MDS with the ARD of	F 641	Bladder Function recorded appropriately on the MDS assessment. 4.MDS or designee will audit 5 residents MDS assessments to ensure accurate coding of foley catheters and bowel and bladder weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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F 641	Continued From page 63 07/08/2021, LPN # 5 stated that section H "Bladder and Bowel" was not correctly coded and that Resident # 104 should not have been coded for a catheter. LPN # 5 stated that sections H0100 and H0300 automatically populates based on the CNAs [certified nursing assistants] documentation of the resident's ADLs [Activities of Daily Living]. LPN # 5 further stated that Resident # 104 did not have a physician's order for the catheter at the time of admission therefore sections H0100 and H0300 should have been taken out and when there is an order Resident # 104 would be coded for H0100. On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. [2] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		

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F 655	Continued From page 64 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655	**F655: Baseline Care Plan** 1.Resident #23 continues to reside in facility. Resident #421 has been discharged from the facility. 2.All residents newly admitted to the facility have the potential to be affected by this alleged deficient practice. Nursing Management will audit and verify current residents have baseline care plan. 3.DON or designee will educate all nurses that a baseline care plan must be developed for each resident within 48 hours of admission to the facility and is separate from the comprehensive care plan, and that the baseline care plan must address the care to meet the resident's immediate needs. 4.DON or designee will audit new admits weekly times 4 weeks and monthly times 2 to ensure residents have a baseline care plan present and developed within 48 hours. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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F 655	Continued From page 65 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a baseline care plan for two of 49 residents in the survey sample, Residents #23 and #421. The facility staff failed to develop a baseline care plan for the use of an anti-anxiety medication and for the use of bed rails for Resident #23 and failed to develop a baseline care plan to address the physician ordered indwelling urinary catheter upon admission for Resident #421. The findings include: 1. Resident #23 was admitted to the facility on 1/10/20, discharged to home on 6/1/21 and readmitted to the facility on 7/13/21. The resident had the diagnoses of but not limited to a stroke, quadriplegia, aphasia, diabetes, anxiety, high blood pressure, COVID-19, and contractures. The admission / 5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/21 coded the resident as moderately impaired in ability to make daily life decisions. Resident #23 was coded as requiring total care for all areas of activities of daily living. On 7/27/21 at 3:37 PM, Resident #23 was observed in bed, with the head of bed elevated, with the half-length side rails for the top half of the	F 655		

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F 655	Continued From page 66 bed up on both sides. A review of the clinical record revealed the following: A physician's order dated 7/13/21 (date of admission) for "1/4 bilateral siderail up for functional mobility." Further review revealed an "Informed Consent for use of Bed Rails" which described benefits and risks signed by the resident representative. In addition, a "Resident Evaluation" form dated 7/13/21 included a section for "Bed Rail Evaluation." This evaluation included an item that documented, "Recommendations...Bed rail(s) is/are recommended at this time." A physician's order dated 7/13/21 for "Lorazepam (1) 0.5 mg, Give 1 tablet via PEG [Percutaneous endoscopic gastrostomy (2)]-Tube at bedtime...." A review of the baseline care plan, with varying dates, for different problem areas, failed to reveal any evidence that the above two care needs, use of side rails and use of an anti-anxiety medication, were care planned. On 7/29/21 at 8:30 AM an interview was conducted with RN #4 (Registered Nurse, the unit manager). She stated that the resident should be care planned for the use of side rails and anti-anxiety medications. On 7/29/21 at 10:48 AM an interview was conducted with LPN #7 (Licensed Practical Nurse). She stated that the resident should be	F 655		

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F 655	Continued From page 67 care planned for the use of side rails and anti-anxiety medications. LPN #7 stated that the nurse who does the admission usually does the baseline care plan. A review of the facility policy, "Care Plans - Baseline" documented, "To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. .. The Interdisciplinary Team will review the healthcare practitioner's orders (e.g., dietary needs, medications, routine treatments, etc.) and implement a baseline care plan to meet the resident's immediate care needs including but not limited to: a. Initial goals based on admission orders; b. Physician orders. .. " On 7/29/21 at 8:45 AM, the Regional Director of Clinical Services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey. References: (1) Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. Information obtained from https://medlineplus.gov/druginfo/meds/a682053.html (2) PEG tube: feeding tube directly into the stomach. This information was obtained from the website: https://www.merriam-webster.com/medical/percutaneous%20endoscopic%20gastrostomy	F 655		

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F 655	Continued From page 68 2. Resident #421 was admitted to the facility on 7/19/21 with diagnosis that included but were not limited to: left knee replacement (artificial joint replacement) (1), hypertension (blood pressure persistently above 140/90 millimeters of mercury) (2) and COPD [chronic obstructive pulmonary disease] (chronic, non-reversible lung disease) (3). The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an ARD (assessment reference date) of 7/26/21, coded Resident #421 as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded Resident #421 as requiring extensive assistance for transfer, hygiene/bathing, limited assistance for ambulation, locomotion and dressing; supervision for eating. A review of MDS Section H- Bowel and Bladder coded Resident #421 as occasionally incontinent for bowel and as having indwelling catheter for bladder. A review of the baseline care plan dated 7/23/21 failed to evidence any documentation addressing an indwelling catheter and the care required for Resident #421. A review of the physician's orders dated 7/19/21, documented in part, "Foley catheter 16 french". An interview was conducted on 7/28/21 at 3:30 PM with LPN (licensed practical nurse) #5, the MDS coordinator. When asked about the indwelling catheter on the care plan for Resident #421, LPN #5 stated, "I know she had a Foley coming into the facility. I do not see any progress	F 655		

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F 655	Continued From page 69 notes on it. She is coded for indwelling catheter on 7/26/21. It should be on the care plan. Nursing is responsible for the baseline care plan and I do the comprehensive care plan." An interview was conducted on 7/28/21 at 3:45 PM with LPN #2. When asked who is responsible for the baseline care plan, LPN #2 stated, "Nursing is responsible. When asked to review Resident #421's care plan for indwelling catheter, LPN #2 stated, "It is not on there and it should be." On 7/27/21 at 11:11 AM, when asked what standard of practice was followed in the facility, ASM (administrative staff member) #2, the director of nursing stated, "We follow our policies and procedures." On 7/28/21 at 5:30 PM, ASM #1, the regional director of clinical services, ASM #2, the director of nursing and ASM #4, the Medical Director were made aware of the concern. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 319. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 282. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120.	F 655		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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F 656	Continued From page 70 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656	**F656: Develop/Implement Comprehensive Care Plan** 1.Residents #40, #9, #172, #171, #104, #11, #33, #62, #52 continue to reside in facility and the care plan has been reviewed to ensure comprehensive care plan has been developed and implemented. Residents #372, #14 and #59 have been discharged from the facility. 2.All residents have the potential to be affected by this alleged deficient practice. Nursing management will conduct an audit on current residents with assistive devices, change in condition and verify care planned has been updated. 3.DON or designee will educate all nurses that care plans must be initiated or updated for assistive devices and changes in condition. 4.DON or designee will audit 5 residents care plans weekly times 4 weeks and a monthly time 2 to ensure that care plans are updated with assistive devices and change in condition. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months.	

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F 656	Continued From page 71 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record reviews and facility document review it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for twelve of 49 residents in the survey sample, Residents #40, #372, #9, #114, #172, #171, #104, #11, #33, #62, #59, and #52. The findings include: 1. The facility staff failed to implement the comprehensive fall care plan which included fall matt placement for Resident #40. Resident #40 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (1) and hemiplegia (2). Resident #40's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 5/28/2021, coded Resident #40 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. Section G coded Resident #40 requiring extensive assistance from one staff member for transfers, walking in the room and toilet use. Section J coded Resident #40 as not having any falls since admission or the prior assessment. On 7/27/2021 at approximately 2:27 p.m., an observation was made of Resident #40 in their room. Resident #40 was observed in bed with	F 656	5.Date of compliance will be August 20, 2021.	

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F 656	Continued From page 72 their cell phone. No fall mats were observed in place beside Resident #40's bed. At this time, an interview was conducted with Resident #40. Resident #40 stated that he had not had any recent falls at the facility and was doing well. When asked about fall mats, Resident #40 stated that he did not think he had any mats on the floor. Additional observations of Resident #40 on 7/28/2021 8:41 a.m. and 7/29/2021 at approximately 8:00 a.m. revealed Resident #40 in bed without fall mats beside the bed. The comprehensive care plan for Resident #40 dated 1/9/2020 documented in part, "At risk for falls due to impaired balance/poor coordination. dx (diagnosis) hx (history) CVA (cerebrovascular accident) with hemiplegia. Date Initiated: 01/09/2020." Under "Interventions/Tasks" it documented in part, " ... Fall Matt(s): Bilateral. Date Initiated: 06/02/2020. Revision on: 01/21/2021..." The "Care Conference Note" for Resident #40 dated 3/19/2021 documented in part, "Topics Discussed: Risk for Falls/Safety..." The "Fall Risk Evaluation" for Resident #40 dated 12/4/2020 documented in part, "...Category: High Risk; Score: 11.0" The physician order's for Resident #40 failed to evidence an order for bilateral fall mats. On 7/29/2021 at approximately 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. LPN #5 stated that an initial care plan was set up by the nursing staff on admission and the	F 656		

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F 656	Continued From page 73	F 656		

comprehensive care plan was completed within 21 days or 7 days after completion of the MDS. LPN #5 stated that they looked at the CAAS (care area assessment) that were triggered from the MDS assessment and the resident's diagnoses to determine the areas specific to the resident which need to be care planned. LPN #5 stated that the nurses updated the care plans in between the admission and quarterly care plan reviews with any new orders, any falls or any new skin conditions. LPN #5 stated that staff were not implementing the care plan if fall mats were an intervention on the care plan and they were not in place.

On 7/29/2021 at approximately 7:59 a.m., an interview was conducted with RN (registered nurse) #4, unit manager. RN #4 stated that the care plan justified the care that was provided for the resident through all departments. RN #4 stated that the care plan covered what care the resident required daily and what their safety level was. RN #4 stated that staff were not implementing the care plan if fall mats were an intervention on the care plan and they were not in place. RN #4 then observed Resident #40 in their room in bed without the fall mats in place.

On 7/27/2021 at approximately 11:15 a.m., ASM #2, the director of nursing stated that the facility followed their policies and procedures as their nursing standard of practice.

On 7/28/2021 at approximately 5:45 p.m., a request was made to ASM (administrative staff member) #1, the regional director of clinical services for the facility policy for implementing the comprehensive care plan.

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F 656	Continued From page 74 The facility policy, "Care Plans, Comprehensive Person-Centered" dated December 2016 documented in part, "...The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being..." On 7/29/2021 at approximately 11:00 a.m., ASM #1, the regional director of clinical services and ASM #2, the director of nursing were made aware of the above concern. No further information was provided prior to exit. References: (1). Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. (2). Hemiplegia: Also called: Hemiplegia, Palsy, Paraplegia, and Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 656		

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F 656	Continued From page 75 2. The facility staff failed to develop a comprehensive care plan for Resident #372 which included use of wandergaurd (1) and wandering, exit-seeking behaviors and elopement (2). Resident #372 was admitted to the facility with diagnoses that included but were not limited to dementia with behavioral disturbance (3) and fracture of left acetabulum (4). Resident #372's most recent MDS (minimum data set), a discharge assessment with an with an ARD (assessment reference date) of 6/10/2021, coded Resident #372 as scoring a 8 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 8- being moderately impaired for making daily decisions. Section E coded Resident #372 displaying rejection of care behaviors during the assessment timeframe. Section G coded Resident #372 as requiring supervision with toilet use, personal hygiene and walking in the corridor. Section M coded Resident #372 as receiving an antipsychotic and an antidepressant medication 6 of 7 days in the assessment period. Resident #372 no longer resided at the facility and could not be observed during the dates of the survey. The deficiency was discovered during the investigation of an elopement which occurred when Resident #372 was in the facility. The comprehensive care plan for Resident #372 failed to evidence a care plan which addressed Resident #372's documented wandering, exit-seeking behaviors and use of a wandergaurd.	F 656		

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F 656	Continued From page 76 The physician order's for Resident #372 failed to evidence an order for use of a wandergaurd. The "Elopement Risk Evaluation" for Resident #372 dated 5/17/2021 documented in part, "...At risk for elopement (implement plan of care for unsafe wandering/exit seeking behavior)...Care plan updated and revised based on evaluation." The progress notes for Resident #372 documented in part, - "1/8/2021 (18:53 (6:52 p.m.) Note Text: Refusing to remain in her room. Attempted to bite writer and bent her finger back when trying to educate her on why she needs to remain in her room to protect her from virus." - "1/18/2021 12:35 (12:35 p.m.) ...Patient is alert and verbal. Refused (Sic.) morning medications, NP (nurse practitioner) [Name of NP] in facility and aware. pt (patient) refused 1130 BS (blood sugar) check. pt propels self in wheelchair and repeatedly roams out in hall, redirected on multiple occasions by staff. no resp [respiratory] distress, denies pain." - "2/23/2021 18:28 (6:28 p.m.) Note Text: Resident refused shower X3 (three times), states I take will take it when I get home to night. Charge nurse tried to tell resident this is your home for now and to please take your shower resident became agitated and started to yell at staff. Resident left alone at this time." - "3/2/2021 12:59 (12:59 p.m.) Pt [patient] up and walking through halls for most of shift..." - "3/3/2021 16:39 (4:39 p.m.) Note Text: Pt alert and verbal. Pt up and walking through halls for most of shift..." - "3/5/2021 18:02 (6:02 p.m.) ...Resident noted calm mannered until noted after 4pm. Resident noted threatening to staff and selective peer..."	F 656		

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F 656	Continued From page 77 - "4/19/2021 23:42 (11:42 p.m.) Note Text: Resident has been walking through the unit this evening..." - "4/22/2021 19:49 (7:49 p.m.) Note Text: resident spit medication out and was verbally aggressive when writer attempted to answer the question that she had ask. Writer [Sic.] was chased from the room." - "5/12/2021 23:11 (11:11 p.m.) Note Text: resident has been redirected several times this shift. She has been told many times during the shift that she is not allowed to push other residents in their wheel chairs but still continues to do so. When reminded, she becomes aggressive and combative with staff." - "5/17/2021 20:30 (8:30 p.m.) Late Entry: Note Text: Writer received call from nursing facility, that they could not locate resident, elopement initiated by staff, staff reports they searched entire facility and surrounding area unable to locate resident. 911 notified received information resident was located safe." - "5/17/2021 20:58 (8:58 p.m.) Late Entry: Note Text: Elopement risk evaluation completed on [Resident #372]. Cognitive impairment present that effects decision making abilities. Able to move about independently in the facility without assistance. Evaluation reveals a history of elopement or elopement attempts in the past. Does have a history of attempting to leave facility unsupervised. Does have a history of attempting to leave facility without notifying staff. [Resident #372] has not made any statements/verbalizations or displayed any behaviors indicating an intent to leave the facility unsupervised. Wandering behavior noted. Family/responsible party has not voiced any concerns over likelihood of patient leaving the center unattended or without staff knowledge.	F 656		

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F 656	Continued From page 78 Based on evaluation [Resident #372] determined to be at risk for elopement. Care plan revised/updated based on evaluation." - "5/17/2021 21:08 (9:08 p.m.) Late Entry: Note Text: MD (medical doctor) and rp (responsible party) was notified at time of event, head to toe skin assessment completed by writer no bruising or open areas noted. Resident was unable to say what happened, due to low bims score. Resident assisted by staff to bed to her room. Resident placed on 1:1 (one to one) monitoring for remainder of shift." - "5/17/2021 00:02 (12:02 a.m.) Note Text: Upon entering residents room to obtain HS (bedtime) blood sugar, writer observed that this resident was not in her room. Building was searched, DON (director of nursing) and Administrator were notified. Police were notified and dispatcher informed writer that the resident went to Walgreens and staff there called the police. DON and ADON (assistant director of nursing) went to retrieve resident. MD and RP [responsible party] were notified that resident had been able to leave the building with wander guard on her ankle. Upon her return, full skin assessment was done and no open area/wounds were found. Staff will continue monitoring resident and observing behaviors." - "5/18/2021 10:58 (10:58 a.m.) Physician progress note...I am seeing her today for an incidence of wandering behavior. Patient had gone out of the facility and walked up to the Walgreens. She was found by the police and brought back to the facility...The daughters tell me that she has had this wandering behavior all her life since she likes to walk a lot. The patient has advancing dementia and due to her wandering behavior she might need a locked dementia unit facility..."	F 656		

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F 656	Continued From page 79 - "5/23/2021 23:22 (10:22 p.m.) Note Text: Resident continue to roam from unit to unit and repeats that she want to go home to New Kent. Resident redirected numerous times. Staff continues to monitor her movement." - "6/10/2021 17:51 (5:51 p.m.) Note Text: Resident discharged to [Name of facility] today for their memory care unit. .." On 7/29/2021 at approximately 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. LPN #5 stated that an initial care plan was set up by the nursing staff on admission and the comprehensive care plan was completed within 21 days or 7 days after completion of the MDS. LPN #5 stated that they looked at the CAAS (care area assessment) that were triggered from the MDS assessment and the resident's diagnoses to determine the areas specific to the resident which need to be care planned. LPN #5 stated that the nurses updated the care plans in between the admission and quarterly care plan reviews with any new orders, any falls or any new skin conditions. LPN #5 stated that residents with exit seeking behaviors, wandering and wearing a wandergaurd should have a care plan addressing these. LPN #5 was asked to provide a copy of the care plan for Resident #372 addressing the elopement, a wandergaurd, the exit seeking behaviors and wandering. On 7/29/2021 at approximately 8:15 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that Resident #372 had a wandergaurd in place prior to the elopement on 5/17/2021. ASM #2 attempted to determine the date the wandergaurd was placed by reviewing the	F 656		

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F 656	Continued From page 80 electronic medical record and stated that they could not determine the date the wandergaurd was placed on Resident #372. ASM #2 stated that Resident #372 displayed behaviors that warranted placing the wandergaurd prior to the elopement on 5/17/2021. ASM #2 reviewed Resident #372's care plan and stated that there was no care plan for the elopement or wandergaurd. On 7/29/2021 at approximately 8:50 a.m., LPN #5 stated that there was no care plan developed for Resident #372's elopement and use of the wandergaurd. On 7/29/2021 at approximately 11:00 a.m., ASM #1, the regional director of clinical services and ASM #2, the director of nursing were made aware of the above concern. The facility policy "Wandering and Elopements" dated March 2019 documented in part, "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaing the least restrictive environment for residents. 1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety." No further information was provided prior to exit. References: 1. Wandergaurd Patient tags transmit a status messages every 10 seconds to enable continual supervision and hospital-wide locating. Exit control- Monitored exit controllers enhance hospital-wide safety with	F 656		

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F 656	Continued From page 81 real time alerts triggering when patients approach or loiter by an open door/elevator. This information was obtained from the website: https://www.stanleyhealthcare.com/hospital-clinics/protection/patients 2. Elopement- legally defined as a patient who is incapable of adequately protecting himself, and who departs the health care facility unsupervised and undetected. This information was obtained from the website: https://psnet.ahrq.gov/web-mm/elopement#:~:text=According%20to%20the%20VA%20National%20Center%20for%20Patient,permitted%20to%20leave%2C%20but%20does%20so%20with%20intent.%22 3. Dementia: 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. 4. Acetablum ...the hip socket (acetabulum). This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19905.htm 3. The facility staff fail failed to develop an accurate and person-centered care plan to address Resident #9's chronic urinary retention, (1), BPH (benign prostatic hyperplasia) (2) and kidney disease (3). Resident #9 was admitted to the facility with diagnoses that include but were not limited to benign prostatic hyperplasia and retention of urine.	F 656		

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F 656	Continued From page 82 Resident #9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/23/2021, coded Resident #9 as scoring a 13 on the brief interview for mental status (BIMS) scale, 13 - being cognitively intact for making daily decisions. Section G coded Resident #9 as requiring extensive assistance of one person for toilet use. Section H coded Resident #9 as having an indwelling urinary catheter. Section O failed to evidence documentation of Resident #9 receiving dialysis (4). On 7/27/2021 at approximately 2:18 p.m., an observation was made of Resident #9 in their bed. Resident #9's urinary catheter collection bag was observed lying directly on the floor beside the bed. The comprehensive care plan dated 10/31/20, documented "Renal insufficiency related to chronic renal failure, dx (diagnosis) bph (benign prostatic hyperplasia). Date Initiated: 10/31/2020" Under "Interventions/Tasks" it documented in part, "...Arrange for transportation to and from Dialysis center on dialysis days. Date Initiated: 10/31/2020, Check access site for lack of thrill/bruit, evidence of infection, swelling or excessive bleeding per facility guidelines. Report abnormalities to physician. Date Initiated: 10/31/2020, Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed. Date Initiated: 10/31/2020, Coordinate dialysis care with the dialysis treatment center. Date Initiated: 10/31/2020..."	F 656		

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F 656	Continued From page 83	F 656		

The physician orders for Resident #9 failed to evidence documentation of Resident #9 receiving dialysis.

On 7/29/2021 at approximately 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. LPN #5 stated that an initial care plan was set up by the nursing staff on admission and the comprehensive care plan was completed within 21 days or 7 days after completion of the MDS. LPN #5 stated that they looked at the CAAS (care area assessment) that were triggered from the MDS assessment and the resident's diagnoses to determine the areas specific to the resident that need to be care planned. LPN #5 stated that they were not sure if Resident #9 received dialysis and would have to check.

On 7/29/2021 at approximately 7:59 a.m., an interview was conducted with RN (registered nurse) #4, unit manager. RN #4 stated that the care plan justifies the care that was provided for the resident through all departments. RN #4 stated that the care plan covered what care the resident required daily and what their safety level was. RN #4 stated that Resident #9 did not receive dialysis. RN #4 stated that Resident #9's care plan was not accurate with the dialysis interventions documented on it and it needed to be updated.

On 7/29/2021 at approximately 8:49 a.m., LPN #5 stated that they had reviewed Resident #9's care plan and had removed the dialysis interventions because Resident #9 did not receive dialysis.

On 7/27/2021 at approximately 11:15 a.m., ASM (administrative staff member) #2, the director of

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F 656	Continued From page 84 nursing stated that the facility followed their policies and procedures as their nursing standard of practice. On 7/28/2021 at approximately 5:45 p.m., a request was made to ASM #1, the regional director of clinical services for the facility policy for comprehensive Care plans. The facility policy, "Care Plans, Comprehensive Person-Centered" dated December 2016 documented in part, "...The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being..." On 7/29/2021 at approximately 11:00 a.m., ASM #1, the regional director of clinical services and ASM #2, the director of nursing were made aware of the above concern. No further information was provided prior to exit. References: 1. Urinary retention is a condition in which you cannot empty all the urine from your bladder. Urinary retention can be acute-a sudden inability to urinate, or chronic-a gradual inability to completely empty the bladder of urine. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention 2. Benign prostatic hyperplasia: An enlarged prostate is also called benign prostatic	F 656		

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F 656	Continued From page 85 hyperplasia (BPH). This information was obtained from the website: https://medlineplus.gov/enlargedprostatebph.html 3. Chronic kidney disease: Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. 4. The facility staff failed to implement Resident #114's comprehensive care plan to administer pain medications per the physician's orders. The physician ordered pain medication for severe pain level ratings and the facility staff administered the pain medication for pain scale ratings below severe pain. Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, coded Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating	F 656		

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F 656	Continued From page 86 the resident was moderately impaired to make daily cognitive decisions. Resident # 114 was coded as limited assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving two days of an antianxiety medication during the look back period. The comprehensive care plan dated 6/25/2021 documented in part, "Focus: Pain related to dependence on renal dialysis, muscle weakness, fluid overload, disease process." the "Interventions/Tasks" documented in part, "Administer pain medication per physician orders. Notify physician if pain frequency/intensity is worsening or of current analgesia regimen has become ineffective." The physician orders dated 6/23/2021 documented, "Hydrocodone-Acetaminophen Tablet (used to treat severe pain) (1) 5-325 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for severe pain." The order dated, 6/1/2021, documented, "Pain Score every shift: 0 = no pain, 1,2,3,4 - mild pain, 5, 6, 7 = moderate pain, 8,9,10 = severe pain. every shift for pain." The July 2021 MAR (medication administration record) documented the physician above order for Hydrocodone - Acetaminophen. The MAR documented the medication was administered on the dates, and times with pain scale ratings below severe pain as ordered by the physician as follows: 7/13/2021 at 9:55 p.m. - pain level - 6 7/15/2021 at 9:53 a.m. - pain level - 6 7/15/2021 at 7:29 p.m. - pain level - 7 7/16/2021 at 10:10 a.m. - pain level - 6 7/16/2021 at 9:03 p.m. - pain level - 7	F 656		

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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 656	Continued From page 87 7/17/2021 at 10:50 a.m. - pain level - 7 7/18/2021 at 5:54 a.m. - pain level - 7 7/18/2021 at 9:09 p.m. - pain level - 7 7/20/2021 at 10:15 p.m. - pain level - 0 7/21/2021 at 11:34 a.m. - pain level - 4 7/22/2021 at 1:26 a.m. - pain level - 6 7/23/2021 at 12:57 a.m. - pain level - 2 7/23/2021 at 9:30 a.m. - pain level - 5 7/24/2021 at 1:10 a.m. - pain level - 0 7/26/2021 at 9:25 a.m. - pain level - 7 An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 2:32 p.m., regarding the purpose of the comprehensive care plan. LPN #3 stated it is to help us care for the resident, also to guild use and let us know what the resident needs. It's the plan of care." ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/29/2021 at 10:41 a.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a614045.html 5. The facility staff failed to implement the comprehensive care plan related to respiratory care and services for Resident #172. Resident #172 was admitted to the facility on 6/16/2021 with diagnoses that included but were	F 656		

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F 656	Continued From page 88 not limited to: chronic obstructive pulmonary disease (COPD -general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), high blood pressure, diabetes and morbid obesity (overweight). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/22/2021, coded Resident #172 as scoring a "2" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she required supervision after set up assistance was provided. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as using oxygen and having a Non-invasive Mechanical Ventilator while a resident at the facility. The comprehensive care plan dated, 6/25/2021, documented in part, "Focus: Has/at risk for respiratory impairment related to COPD and acute and chronic respiratory failure." The "Interventions/Tasks" documented, "Administer oxygen per physician order." The physician order dated, 7/2/2021, documented, "Oxygen at 3 liters/minute via nasal cannula every shift." Observation was made of on 7/27/2021 at 11:40 a.m. observation revealed Resident #172 in her bed with her oxygen on via a nasal cannula (a two-prong tube that inserts into the nose) connected to an oxygen concentrator that was	F 656		

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F 656	Continued From page 89	F 656		

running. The oxygen concentrator flow meter was set at 4.5 LPM (liters per minute). Further observation revealed the oxygen concentrator was out of Resident #172's reach. A second observation was made on 7/28/2021 at 8:07 a.m. Resident #172 was in her bed with the oxygen on via a nasal cannula that was connected to an oxygen concentrator that was running. Observation revealed the oxygen concentrator flow meter was set with the bottom of the ball on the 5 LPM line.

An observation was made of Resident #172 on 7/28/2021 at 12:07 p.m., with LPN (licensed practical nurse) #6. When asked to read the resident's oxygen concentrator, LPN #6 stated, "Oh Lord. I believe she is supposed to be on 3 LPM (liters per minute). LPN #6 proceeded to check the physician's orders for Resident #172 on the computer and verified the resident was supposed to be on 3 LPM. When asked if the comprehensive care plan intervention to administer oxygen as ordered by the physician was implemented, LPN #6 stated, "No, Ma'am." When asked the purpose of the comprehensive care plan, LPN #6 stated, "It's the best care for the resident."

ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 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.

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F 656	Continued From page 90 6. The facility staff failed to implement the care plan related to respiratory care and services for Resident #171. Resident #171 was admitted to the facility on 7/14/2021 with diagnoses that included but were not limited to: Cancer of the esophagus (the muscular canal that transports food from the mouth to the stomach) (1), Bipolar Disorder (a mental disorder characterized by episodes of mania and depression) (2), and muscle weakness. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 7/20/2021, coded Resident #171 as scoring a "14" 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 having used oxygen while a resident at the facility. The comprehensive care plan, dated, 7/27/2021, documented, "Focus: Has/at risk for respiratory impairment related to esophageal cancer." The "Interventions" documented in part, "Administer oxygen per physician order." On 7/27/2021 at 11:30 a.m., observation revealed Resident #171 was lying in his bed. He had oxygen in use via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set with the bottom of the ball sitting on the line for 2 LPM (liters per minute). A second observation was	F 656		

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F 656	Continued From page 91 made on 7/28/2021 at 9:04 a.m. Resident #171 was lying in the bed. He had oxygen in use via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set with the bottom of the ball sitting on the line for 2 LPM. On 7/28/2021 at 12:36 p.m. an observation was made of Resident #171 was lying in his bed. He had oxygen in use via a nasal cannula connected to an oxygen concentrator that was running. LPN (licensed practical nurse) #6 was in attendance. When asked the flow rate setting of Resident #171's oxygen, LPN #6 stated, "Almost 3 LPM." When asked how to read the oxygen concentrator for the prescribed rate, LPN #6 stated the line for the prescribed rate should be through the center of the ball. When asked if the intervention to administer oxygen per physician's orders on the comprehensive care plan was implemented, LPN #6 stated, "No, Ma'am." When asked the purpose of the comprehensive care plan, LPN #6 stated, "It's the best care for the resident." ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 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 208. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.	F 656		

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F 656	Continued From page 92 7. The facility staff failed to develop a comprehensive care plan to address Resident # 104's condom catheter and care. Resident # 104 was admitted to the facility with diagnoses that included but were not limited to: Parkinson's disease [1] and multiple sclerosis [2]. Resident # 104's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 07/08/2021, coded Resident # 104 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Resident # 18 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section H "Bladder and Bowel" Resident # 104 was coded under "H0100" as having an indwelling catheter and an external catheter. The POS [physician's order sheet] for Resident # 104 dated 07/28/2021 documented, "Urinary Catheter: Condom change PRN [as needed] if obstructed. Order Date: 07/28/2021." The comprehensive care plan for Resident # 104 dated 07/05/2021 failed to evidence documentation to address Resident # 104's condom catheter. The facility's progress notes for Resident # 104 dated 07/02/2021 at 4:23 p.m., documented in part, "Resident Evaluation ...Arrived via [by] stretcher ...Urinary catheter in place ..." On 07/28/2021 at 1:30 p.m., an interview was conducted with LPN [Licensed practical nurse] # 5, MDS coordinator. After reviewing Resident #	F 656		

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F 656	Continued From page 93 104's comprehensive care plan dated 07/05/2021, LPN # 5 was asked if the comprehensive care plan addressed Resident # 104's condom catheter and care. LPN # 5 stated, "There was no order on admission therefore it didn't make it on the care plan." When asked if a care plan should have been developed to address Resident # 104's catheter care LPN # 5 stated yes. On 7/29/2021 at approximately 7:45 a.m., an interview was conducted with LPN # 5. LPN # 5 stated that an initial care plan was set up by the nursing staff on admission and the comprehensive care plan was completed within 21 days or 7 days after completed of the MDS (minimum data set). LPN # 5 stated that they looked at the CAAS (care area assessment) that were triggered from the MDS assessment and the diagnosis to determine areas specific to the resident which need to be care planned. LPN # 5 stated that the nurses updated the care plans in between the admission and quarterly care plan reviews with any new orders, falls or skin conditions. On 7/29/21 at approximately 7:59 a.m., an interview was conducted with RN (registered nurse) # 4, unit manager. RN # 4 stated that care plans were updated every three months and as needed with new orders and interventions put into place. RN # 4 stated that the care plan justified the care that was provided for the resident through all departments. RN # 4 stated that the care plan covered what care the resident required daily and what their safety level was. On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of	F 656		

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F 656	Continued From page 94 clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. [2] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. 8. The facility staff failed to develop a comprehensive care plan to address Resident # 11's tracheostomy care. Resident # 11 was admitted to the facility with diagnoses that include but not limited to: skin cancer of scalp and neck, respiratory failure with hypoxia [2], acquired absence of larynx [3] and tracheostomy [4]. Resident # 11's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/27/2021, coded Resident # 11 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Section "O Special Treatments,	F 656		

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F 656	Continued From page 95 Procedures and Programs" coded Resident # 11 for "Tracheostomy care" while a resident. The physician's order dated 04/01/2021 for Resident # 11 documented, "Keep a spare trach and ambu [1] bag with pt [patient] at all times." The comprehensive care plan for Resident # 11 dated 04/21/2021 failed to evidence interventions for tracheostomy care. On 07/29/2021 at 7:30 a.m., an interview was conducted with LPN # 3, MDS coordinator. After LPN #3 reviewed Resident # 11's comprehensive care plan dated 04/21/2021, LPN #3 was asked if a care plan was developed to address Resident # 11's tracheostomy care. LPN # 3 stated no. At 7:45 a.m., LPN # 3 provided a corrected copy of Resident # 11's comprehensive care plan with tracheostomy care included. On 07/29/2021 at 7:50 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing. After ASM #2 reviewed Resident # 11's comprehensive care plan dated 04/21/2021, ASM #2 was asked if a care plan was developed for Resident # 11's tracheostomy care. ASM # 2 stated, "The interventions did not address trach [tracheostomy] care." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit.	F 656		

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F 656	Continued From page 96 References: [1] A self-refilling bag-valve-mask unit with a 1 -1.5 liter capacity, used for artificial respiration which, while suboptimal for the non-intubated patient, is effective for ventilating and oxygenating intubated patients, allowing both spontaneous and artificial respiration. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/Ambu+bag 9. The facility staff failed to develop Resident #33's comprehensive care plan to include and address the use of antipsychotic medication. Resident #33 was admitted to the facility on 10/2/15. Resident #33's diagnoses included but were not limited to diabetes, heart failure and difficulty swallowing. Resident #33's annual minimum data set assessment with an assessment reference date of 5/18/21, coded the resident's cognition as severely impaired. Section N coded Resident #33 as having received antipsychotic medication six out of the last seven days. Section V coded psychotropic drug use as a triggered care area and documented this would be care planned. Review of Resident #33's clinical record revealed a physician's order dated 1/15/21 for Seroquel (1) 12.5 mg (milligrams) two times a day every Monday, Tuesday, Thursday, Friday, Saturday and Sunday for schizophrenic effect disorder (1). Resident #33's comprehensive care plan revised on 7/9/20 failed to document information regarding antipsychotic medication use. On 7/28/21 at 3:28 p.m., an interview was	F 656		

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F 656	Continued From page 97 conducted with LPN (licensed practical nurse) #5 (the MDS [minimum data set] coordinator). LPN #5 stated she is supposed to develop a psychotropic drug use care plan when a resident receives an antipsychotic medication and psychotropic drug use triggers as a care area on the MDS. LPN #5 reviewed Resident #33's comprehensive care plan and stated the resident did not have a care plan for antipsychotic use. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy, "Care Plans, Comprehensive Person-Centered" dated December 2016 documented in part, "...The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being..." No further information was presented prior to exit. Reference: (1) "Quetiapine (Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html	F 656		

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F 656	Continued From page 98 10. The facility staff failed to develop Resident #62's comprehensive care plan to include and address the use of antipsychotic medication. Resident #62 was admitted to the facility on 1/20/17. Resident #62's diagnoses included but were not limited to obsessive compulsive disorder, major depressive disorder and low back pain. Resident #62's significant change in status minimum data set assessment with an assessment reference date of 3/15/21, coded the resident as being cognitively intact. Section N coded Resident #62 as having received antipsychotic medication six out of the last seven days. Section V coded psychotropic drug use as a triggered care area and documented this would be care planned. Review of Resident #62's clinical record revealed a physician's order dated 3/10/21 for Seroquel (1) 25 mg (milligrams) by mouth at bedtime for psychosis. Resident #62's comprehensive care plan revised on 2/2/17 failed to document information regarding antipsychotic medication use. On 7/28/21 at 3:28 p.m., an interview was conducted with LPN (licensed practical nurse) #5 (the MDS [minimum data set] coordinator). LPN #5 stated she is supposed to develop a psychotropic drug use care plan when a resident receives an antipsychotic medication and psychotropic drug use triggers as a care area on the MDS. LPN #5 reviewed Resident #62's comprehensive care plan and stated the resident did not have a care plan for antipsychotic use. On 7/28/21 at 4:52 p.m., ASM (administrative	F 656		

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F 656	Continued From page 99 staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. Reference: (1) "Quetiapine (Seroquel) extended-release tablets are also used along with other medications to treat depression." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html 11. The facility staff failed to develop the comprehensive care plan to include and address Resident #59's AV (arterial-venous) shunt care and dialysis. Resident #59 was admitted to the facility on 1/27/21 with diagnosis that included but were not limited to: diabetes mellitus (inability of insulin to function normally in the body) (1), ESRD [end stage renal disease] (inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance) (2), heart failure (inability of the heart to pump enough blood to maintain normal body requirements) (3) and cerebrovascular accident (abnormal condition in which a hemorrhage or blockage of the blood vessels of the brain leads to a lack of oxygen) (4). The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 6/14/21, coded Resident #59 as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score,	F 656		

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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 656	Continued From page 100 indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for locomotion, limited assistance with dressing and bathing; supervision was required for hygiene, transfer, and bed mobility, walking, eating and dressing. Section O: special treatments and procedures, documented, "Dialysis= yes." A review of the physician orders dated 6/10/21, documented in part, "Dialysis: site of arterial vascular shunt-check bruit and thrill every shift." A review of the comprehensive care plan dated 6/10/21, failed evidence any documentation regarding checking Resident #59's AV (arterial-venous) fistula for a bruit or thrill and failed to evidence any documentation regarding dialysis. An interview was conducted on 7/28/21 at 3:30 PM with LPN (licensed practical nurse) #5, the MDS coordinator regarding the purpose of the comprehensive care plan. LPN #5 stated, "The purpose of the care plan is to alert the staff on how to care for the patient, what conditions and how to maintain their health. For a dialysis patient I would expect to see the dialysis treatments on specific days, if there is a fistula/shunt, checking for bruit and thrill, remove dressing post dialysis and checking for bleeding. The resident would be at risk for infection due to catheter, so you would monitor the signs and symptoms of infection, change dressing per physician orders. Anything that triggers from the MDS we would put on the care plan". When asked if she saw dialysis or checking the AV fistula for a bruit or thrill on Resident #59's	F 656		

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F 656	Continued From page 101 comprehensive care plan, LPN #5 stated, "No, I don't see it. I will revise it." On 7/27/21 at 11:11 AM, when asked what standard of practice was followed in the facility, ASM (administrative staff member) #2, the director of nursing stated, "We follow our policies and procedures." According to the facilities "Care Plans, Comprehensive Person-Centered" revised December 2016, which documents in part, "The comprehensive, person-centered care plan will: incorporate identified problem areas, describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being." According to the facility's "End-Stage Renal Disease, Care of a Resident With" revised September 2010, which documents in part, "The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care." On 7/28/21 at 5:30 PM, ASM #1, the regional director of clinical services, ASM #2, the director of nursing and ASM #4, the Medical Director were made aware of the concern. 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 160. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 498. (3) Barron's Dictionary of Medical Terms for the	F 656		

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F 656	Continued From page 102 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 259. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. 12. The facility staff failed to implement the comprehensive care plan for the coordination of dialysis care and services for Resident #52, between the facility and the dialysis center. Resident #52 was most recently readmitted to the facility on 6/4/21 with the diagnoses of but not limited to sepsis, diabetes, stroke, dysphasia, dysphagia, insomnia, seizures, high blood pressure, end stage renal disease, pacemaker, and COVID-19. The most recent MDS (Minimum Data Set) was a quarterly / 5-day assessment with an ARD (Assessment Reference Date) of 6/9/21. The resident was coded as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive assistance for hygiene, toileting, dressing, and transfers; and supervision for eating. A review of the comprehensive care plan revealed one dated 11/30/20 for "Renal insufficiency related to chronic renal failure, presence of fistula/graft/catheter." This care plan included an intervention dated 11/30/20 for "Coordinate dialysis care with the dialysis treatment center." A review of the clinical record revealed a physician's order dated 6/28/21 for "Hemodialysis Diagnosis: ESRD (End Stage Renal Disease). Dialysis days and time: Monday, Wednesday, Friday. Pick up time: 11:30am. Dialysis Center:	F 656		

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F 656	Continued From page 103 (name, address, phone number, and transportation company contact was documented)." A review of the dialysis communication log revealed forms on which the facility was to document on the top half the following information as applicable, for the dialysis center review prior to performing dialysis, the following information: Vital signs, blood sugar, last pain medication given, wound sites, special precautions, additional comments. The second half of the form, the dialysis center was to document for the facility to review upon return from dialysis the following information: Pre dialysis weight and vital signs, post dialysis weight and vital signs, duration of treatment, medications administered, and new orders or comments. A review of the dialysis log for July 2021 revealed the following: July 2, 2021 - there was no communication log documentation from either facility to the other. July 7, 2021 - the dialysis center did not document on the communication log pertinent data for the facility. July 8, 2021 - the dialysis center did not document on the communication log pertinent data for the facility. July 16, 2021 - the dialysis center did not document on the communication log pertinent data for the facility. July 19, 2021 - there was no communication log documentation from either facility to the other. July 23, 2021 - the dialysis center did not document on the communication log pertinent	F 656		

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F 656	Continued From page 104 data for the facility. July 28, 2021 - the facility did not document on the communication log pertinent data for the dialysis center. On 7/29/21 at 10:44 AM an interview was conducted with RN #4 (Registered Nurse). When asked about the purpose of the dialysis communication log, RN #4 stated it was to document and report to or from dialysis any change of condition, vital signs, weights, or alterations in relevant care and treatment. She stated that even if there were no changes in conditions or treatments, that at the very least, the vital signs should be documented by both facilities. On 7/29/21 at 10:48 AM an interview was conducted with LPN #7 (Licensed Practical Nurse). When asked what the purpose of the dialysis communication book was, she stated that it was for recording and communicating the resident's vital signs and weight to and from the dialysis center. When asked about logs that were left blank, and how either facility knew what the vitals and weights were, LPN #7 stated, "They won't know." When asked if the intervention to coordinate dialysis care and services with the dialysis treatment center, on Resident #52's comprehensive care plan dated 11/30/21, was being implemented if the communication logs were blank or incomplete, LPN #7 stated that it was not. On 7/29/21 at 8:45 AM, the Regional Clinical Services Director, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. ASM #1 stated that it had	F 656		

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F 656	Continued From page 105 already been identified that the completion of the dialysis communication log was a problem. No further information was provided by the end of the survey.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 657	**F657: Care Plan Timing and Revision** 1.Residents #105, #9, and #82 continue to reside in facility and the care plan has been reviewed to ensure comprehensive care plan has been updated and revised. Resident #114 has been discharged from the facility. 2.All residents have the potential to be affected by this alleged deficient practice. Nursing management will conduct audit care plans to verify care plans initiated or updated for assistive devices, psychotropic medications and change in condition. 3.DON or designee will educate all nurses that care plans must be initiated or updated to include assistive devices, psychotropic medication and change in condition. 4.DON or designee will audit 5 resident's care plans weekly times 4 weeks and monthly times 2 to ensure that care plans are initiated or updated for change in condition, psychotropic medications, and assistive devices. Any identified issues will be immediately corrected. Results will be reported to	

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F 657	Continued From page 106 was determined that the facility staff failed to review and/or revise the comprehensive care plan for four of 49 residents in the survey sample, Residents #105, #9, #114 and Resident # 82. The facility staff failed to review and/or revise Resident #105's comprehensive care plan for the use of bedrails, failed to review and revise Resident #9's comprehensive care plan to address an indwelling Foley catheter and failed to review and revise Resident #114's and Resident # 82's comprehensive care plans to address the use of antianxiety medication prescribed by the physician. The findings include: 1. The facility staff failed to review and/or revise Resident #105's comprehensive care plan for the use of bedrails. Resident #105 was admitted to the facility on 8/20/20. Resident #105's diagnoses included but were not limited to history of a stroke, diabetes and high blood pressure. Resident #105's quarterly minimum data set assessment with an assessment reference date of 7/8/21, coded the resident's cognition as severely impaired. Review of Resident #105's clinical record revealed a physician's order dated 5/19/21 for 1/4 side rails (bedrails) for bed mobility. Resident #105's comprehensive care plan initiated on 8/21/20 failed to document information regarding side rails or bedrails. On 7/27/21 at 11:35 a.m., Resident #105 was observed in bed with bilateral quarter bedrails.	F 657	Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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F 657	Continued From page 107 On 7/28/21 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated care plans tell employees how to care for residents. LPN #3 stated residents' care plans should include the use of bedrails so employees know they are used to foster mobility and not as a restraint. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Care Plans, Comprehensive Person-Centered" documented, "8. The comprehensive, person-centered care plan will: b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being..." No further information was presented prior to exit. 2. The facility staff failed to review and revise Resident #9's comprehensive care plan to include an indwelling urinary catheter. Resident #9 was admitted to the facility with diagnoses that include but were not limited to benign prostatic hyperplasia (2) and retention of urine (3). Resident #9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/23/2021, coded Resident #9 as scoring a 13 on the brief interview for mental status (BIMS) scale, 13 - being cognitively intact for making daily decisions.	F 657		

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F 657	Continued From page 108 Section G coded Resident #9 as requiring extensive assistance of one person for toilet use. Section H coded Resident #9 as having an indwelling urinary catheter. On 7/27/2021 at approximately 2:18 p.m., an observation was made of Resident #9 in their bed. Resident #9's urinary catheter collection bag was observed lying directly on the floor beside the bed. At this time, an interview was conducted with Resident #9. When asked about the urinary catheter collection bag on the floor, Resident #9 stated, "I have so many tubes in me, I can't keep up with them. The nurses take care of them all for me." When asked how long he had the urinary catheter in place, Resident #9 stated that he was not sure of the exact date but had it in for "a while" now. The physician orders for Resident #9 documented in part, - "Catheter output every shift. Order Date: 05/06/2021." - "Change Foley (catheter) bag PRN (as needed). Order Date: 01/22/2021." - "Urinary catheter: Hydronephrosis (5) with renal and ureteral calculous [sic] (6) obstruction size: 166[sic] FR (french) balloon size 10 cc (cubic centimeters) change PRN (as needed) for obstruction. Order Date: 7/26/2021." The comprehensive care plan dated 10/31/2020, for Resident #9 failed to evidence documentation of an indwelling urinary catheter for Resident #9. On 7/29/2021 at approximately 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. LPN #5 stated that an initial care plan was set up by	F 657		

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F 657	Continued From page 109 the nursing staff on admission and the comprehensive care plan was completed within 21 days or 7 days after completion of the MDS. LPN #5 stated that they looked at the CAAS (care area assessment) that were triggered from the MDS assessment and the resident's diagnoses to determine the areas specific to the resident which need to be care planned. LPN #5 stated that the nurses updated the care plans in between the admission and quarterly care plan reviews with any new orders, any falls or any new skin conditions. LPN #5 stated that urinary catheters should be on the care plan. On 7/29/2021 at approximately 7:59 a.m., an interview was conducted with RN (registered nurse) #4, unit manager. RN #4 stated that care plans were updated every three months and as needed with new orders and interventions put into place. RN #4 stated that the care plan justified the care that was provided for the resident through all departments. RN #4 stated that the care plan covered what care the resident required daily and what their safety level was. RN #4 stated that urinary catheters should be on the care plan. On 7/29/2021 at approximately 11:00 a.m., ASM #1, the regional director of clinical services and ASM #2, the director of nursing were made aware of the above concern. No further information was provided prior to exit. References: 1. Chronic kidney disease: Kidneys are damaged and can't filter blood as they should. This information was obtained from the website:	F 657		

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F 657	Continued From page 110 https://medlineplus.gov/chronickidneydisease.html. 2. Benign prostatic hyperplasia: An enlarged prostate is also called benign prostatic hyperplasia (BPH). This information was obtained from the website: https://medlineplus.gov/enlargedprostatebph.html 3. Urinary retention is a condition in which you cannot empty all the urine from your bladder. Urinary retention can be acute-a sudden inability to urinate, or chronic-a gradual inability to completely empty the bladder of urine. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention 4. Hemodialysis: Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm. 5. Hydronephrosis is the swelling of a kidney due to a build-up of urine. This information was obtained from the website: https://www.kidney.org/atoz/content/hydronephrosis 6. Renal calculus: Kidney stones (also called renal stones or urinary stones) are small, hard deposits that form in one or both kidneys; the stones are made up of minerals or other compounds found in urine. This information was obtained from the website: https://medlineplus.gov/genetics/condition/kidney-stones/	F 657		

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F 657	Continued From page 111 3. The facility staff failed to review and revise Resident #114's comprehensive care plan to address the use of an anti-anxiety medication prescribed by the physician on 6/14/2012. Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, coded Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as limited assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving two days of an antianxiety medication during the look back period. The physician order dated 6/14/2021, documented, "Ativan tablet (used to treat anxiety) (4) 0.5 mg (milligrams) (Lorazepam) Give .25 mg by mouth every 8 hours as needed for anxiety."	F 657		

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F 657	Continued From page 112 The comprehensive care plan for Resident #114 dated, 6/25/2021, documented in part, "Focus: At risk for adverse effects related to use of anti-depression medication." Review of the care plan failed to evidence a care plan addressing the use of an anti-anxiety medication. Review of the June 2021 MAR (medication administration record) for Resident #114 documented the above physician order for Ativan. The Ativan was documented as administered on the following dates and times: 6/16/2021 at 11:16 a.m. 6/16/2021 at 8:09 p.m. 6/19/2021 at 10:22 p.m. 6/23/2021 at 12:48 p.m. 6/25/2021 at 3:37 a.m. 6/25/2021 at 10:51 a.m. 6/27/2021 at 10:48 a.m. 6/30/2021 at 11:40 a.m. The July 2021 MAR for Resident #114 documented the above physician's order for Ativan. The Ativan was documented as having been administered on the following dates and times: 7/1/2021 at 2:01 p.m. 7/2/2021 at 10:46 p.m. 7/4/2021 at 12:06 a.m. 7/10/2021 at 4:14 a.m. 7/11/2021 at 6:57 p.m. 7/15/2021 at 7:29 p.m. 7/16/2021 at 10:10 a.m. 7/18/2021 at 11:16 a.m. 7/18/2021 at 10:48 p.m. 7/20/2021 at 11:02 a.m. 7/21/2021 at 7:08 a.m. 7/21/2021 at 6:42 p.m.	F 657		

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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 657	Continued From page 113 7/22/2021 at 11:56 a.m. 7/23/2021 at 7:08 a.m. An interview was conducted with LON (licensed practical nurse) #5 on 7/29/2021 at 7:45 a.m. regarding development of resident care plans. LON #5 stated the nurses, on admission, do the interim care plan. She stated she had 21 days from the admission date to complete the care plan. When asked if a new physician order for an anti-anxiety medication, should that be care planned, LON #5 stated that yes, it should be care planned, the unit manager should update it (care plan). Resident #114's comprehensive care plan was reviewed with LON #5. After reviewing Resident #114's comprehensive care plan, LON #5 stated she did not see a care plan for the use of the anti-anxiety medication. LON #5 stated would need to check on this. On 7/29/2021 at 8:20 a.m., LON #5 returned and stated there was no care plan for the use of the anti-anxiety medication but she would be adding it to the care plan. SAM #1, the regional director of clinical services, was made aware of the above findings on 7/29/2021 at 11:38 a.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 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) Barron's Dictionary of Medical Terms for the	F 657		

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F 657	Continued From page 114 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 43. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html 4. The facility staff failed to review and revise the comprehensive care plan to address the use of an anti-anxiety medication for Resident #82 prescribed by the physician on 8/21/19. Resident #82 was admitted to the facility on 4/12/19 with the diagnoses of but not limited to chronic obstructive pulmonary disease, high blood pressure, diabetes, obesity, migraines, chronic kidney disease, and anxiety disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/24/21. The resident was coded as cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing; limited assistance for transfers and toileting; supervision for dressing and hygiene; and independent for eating. A review of the clinical record revealed an order dated 8/21/19 for Clonazepam (1) 5 mg (milligrams) once daily for generalized anxiety disorder. A review of the comprehensive care plan failed to reveal that comprehensive care plan was reviewed and revised to reflect and address the use of an anti-anxiety medication as prescribed by the physician on 8/21/19, for Resident #82. On 7/29/21 at 10:44 AM in an interview with RN	F 657		

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F 657	Continued From page 115 #4 (Registered Nurse) the unit manager, she stated that the care plan should have been revised to include the use of an anti-anxiety medication. On 7/29/21 at 8:45 AM, the Regional Director of Clinical Services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey. (1) Clonazepam - is used to treat certain types of seizures and to relieve panic attacks. Information obtained from https://medlineplus.gov/druginfo/meds/a682279.html	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and review of facility documentation it was determined the facility staff failed to ensure professional standards for two of 49 residents in the survey sample, (Resident #421 and # 82). 1. The facility staff failed to clarify Resident #421's as needed pain medication order. The 7/19/21, physician order documented the maximum amount of acetaminophen for a 24 hour period should not exceed 3 grams (3000	F 658	**F658: Services Provided Meet Professional Standards** 1.Residents #421 and #82 no longer reside in the facility. 2.All residents have the potential to be affected by this alleged deficient practice. Nursing management will audit current residents to validate physician orders have a prn pain scale and nurses administered per the prn pain scale parameter . 3.DON or designee will educate all facility nurses to ensure that orders for prn pain medications have a pain scale and administered per the pain scale parameters.	

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F 658	Continued From page 116 mg). The 7/20/21, physician order documented to administer Acetaminophen tablet, 975 mg by mouth every 6 hours for pain (4 times a day for a total of 3900 milligram of Acetaminophen per 24-hour period). 2. The facility staff failed to clarify Resident #82's physician orders for two as needed pain medications to determine which and when to administer each as needed pain medication. The findings include: 1. Resident #421 was admitted to the facility on 7/19/21 with diagnosis that included but were not limited to: left knee replacement (artificial joint replacement) (6), hypertension (blood pressure persistently above 140/90 millimeters of mercury) (7) and COPD [chronic obstructive pulmonary disease] (chronic, non-reversible lung disease) (8). The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an ARD (assessment reference date) of 7/26/21, 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. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for transfer, hygiene/bathing, limited assistance for ambulation, locomotion and dressing; supervision for eating. A review of MDS Section H- Bowel and Bladder coded the resident as occasionally incontinent for bowel and indwelling catheter for bladder. A review of the care plan dated 7/23/21,	F 658	4.DON or designee will audit orders of residents with prn pain medications to verify the orders include the pain scale and the pain scale parameters were followed that medication weekly times 4 weeks and monthly times 2 to ensure facility staff are following the pain scale parameter . Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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F 658	Continued From page 117 documented in part, "FOCUS: Pain (specify location) related to left knee. INTERVENTIONS: Encourage/assist to reposition frequently for comfort as needed. Notify physician if pain frequency/intensity is worsening or of current analgesia regimen has become ineffective. Provide education to family/patient related to pain." A review of the physician orders dated 7/19/21, documented in part, "The maximum amount of acetaminophen for a 24 hour period should not exceed 3 grams (3000 mg)." A review of the physician orders dated 7/20/21, documented in part, "Acetaminophen tablet, give 975 mg by mouth every 6 hours for pain." A review of the MAR (medication administration record), documented in part, "Acetaminophen 975 mg by mouth every 6 hours administered 7/20/21 at 6:00 AM, 12:00 PM, 6:00 PM, 7/21/21 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; 7/22/21 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; 7/23/21 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; 7/24/21 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; 7/25/21 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; 7/26/21 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; 7/27/21 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; 7/28/21 at 12:00 AM, 6:00 AM, 12:00 PM, 6:00 PM; 7/21/21 at 12:00 AM, 6:00 AM and 12:00 PM. Resident #421 received Acetaminophen 975 mg every 6 hours (4 times a day for a total of 3900 milligram of Acetaminophen per 24-hour period). This amount exceeds the total maximum amount of acetaminophen ordered to be administered within a 24-hour period by 900 milligram.	F 658		

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F 658	Continued From page 118 An interview was conducted on 7/28/21 at 3:05 PM with LPN (licensed practical nurse) #2. When asked to review the acetaminophen order for Resident #421, LPN #2 stated, "975mg Tylenol every 6 hours = 3900 mg. There is an order for Tylenol not to exceed 3000 mg daily. She (Resident #421) has been exceeding the 3000 mg daily dose. We get the orders and there are order sets when admitted. I think there are 18 order sets for new admissions. I will call the physician and get the order changed so it is right." When asked who has the responsibility for verifying and following physician orders, LPN #2 stated, "We do, the nurses." An interview was conducted on 7/28/21 at 3:15 PM with LPN #6. When asked to review the acetaminophen order for Resident #421, LPN #6 stated, "Here are the 18 order sets on this new admission. The hospital's physicians order Tylenol 975 mg by mouth every 6 hours. That physician group is the only ones who order it like that." On 7/27/21 at 11:11 AM, when asked what standard of practice was followed in the facility, ASM (administrative staff member) #2, the director of nursing stated, "We follow our policies and procedures." According to the facility's "Administering Medications" policy revised December 2012, documented in part, 'If a dosage is believed to be inappropriate or excessive for a resident, the person preparing or administering the medication shall contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns."	F 658		

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F 658	Continued From page 119 On 7/28/21 at 5:30 PM, ASM #1, the regional director of clinical services, ASM #2, the director of nursing and ASM #4, the Medical Director were made aware of the concern. References: (6) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 319. (7) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 282. (8) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. 2. The facility staff failed to clarify Resident #82's physician's orders for two as needed pain medications to determine which and when to administer each as needed pain medication. Resident #82 was admitted to the facility on 4/12/19 with the diagnoses of but not limited to chronic obstructive pulmonary disease, high blood pressure, diabetes, obesity, migraines, chronic kidney disease, and anxiety disorder. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/24/21. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for bathing; limited assistance for transfers and toileting; supervision for dressing and hygiene; and independent for eating.	F 658		

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F 658	Continued From page 120 A review of the physician's orders revealed one dated 4/21/19 for Pain Relief Tab (acetaminophen) (1) 500 mg, give 2 tablets every 6 hours as needed for pain. Further review of the physician's orders revealed one dated 10/ 11/19 for Oxycodone (2) 5 mg (milligrams) capsule, give 2.5 mg by mouth once daily as needed for chronic pain. Take at least 6 hours after the scheduled morning dose. Neither order provided parameters such as for moderate or severe and or a numeral pain rating parameter for which and when each as needed pain medication may be given. (Note: (1) Acetaminophen (i.e. Tylenol) - is used to treat mild to moderate pain; and (2) Oxycodone - is used to relieve moderate to severe pain.) Further review of the physician's orders revealed one dated 9/18/19 for "Pain Score every shift 0 = No pain; 1,2,3,4 = Mild Pain; 5,6,7 = Moderate pain; 8,9,10 = Severe pain." A review of the July 2021 MAR (Medication Administration Record) revealed that a "0" was documented as the pain score for each shift of the month. No shift had any other number documented. A review of the July 2021 MAR revealed that on 7/23/21 at 6:51 PM the resident was administered a dose of the oxycodone for a pain level of "2." On 7/24/21 at 4:48 PM the resident was administered a dose of the Pain Relief Tab for a pain level of "3." On 7/29/21 at 8:30 AM an interview was conducted with RN #4 (Registered Nurse, the unit manager). She stated that the orders should	F 658		

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F 658	Continued From page 121 have been clarified on what parameters each one could be given. RN #4 stated that administering the oxycodone was not appropriate for a pain level of "2." She stated that nurses should not be making a determination, that there should be parameters set by the physician. On 7/29/21 at 8:45 AM, the Regional Director of Clinical Services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey. (1) Tylenol - Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html (2) Oxycodone - Information obtained from https://medlineplus.gov/druginfo/meds/a682132.html	F 658		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to the implement assistive device	F 689	**F689: Free of Accident Hazards/Supervision/Devices** 1.Resident #40 continues to reside in the facility. Care plan has been updated. 2.All residents have the potential to be affected by this alleged deficient practice. Nursing management will conduct an audit on current residents with fall mat orders and verify are in place and care planned . 3.DON or designee will educate staff on ensuring that fall mats must be in place and care planned.	

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F 689	Continued From page 122 safety measures to ensure an environment free of accident hazards for one of 49 residents in the survey sample, Resident #40. The facility staff failed to implement Resident #40's fall mat on 7/26/21, 7/27/21, the morning of 7/28/21 and 7/29/21 per the comprehensive plan of care. The findings include: Resident #40 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (1) and hemiplegia (2). Resident #40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/28/2021, coded Resident #40 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. Section G documented Resident #40 requiring extensive assistance from one staff member for transfers, walking in the room and toilet use. Section J documented Resident #40 not having any falls since admission or the prior assessment. On 7/27/2021 at approximately 2:27 p.m., an observation was made of Resident #40 in their room. Resident #40 was observed in bed with their cell phone. No fall mats were observed in place beside Resident #40's bed. At this time, an interview was conducted with Resident #40. Resident #40 stated that he had not had any recent falls at the facility and was doing well. When asked about fall mats, Resident #40 stated that he did not think he had any mats on the floor.	F 689	4.DON or designee will audit 5 Residents with fall mats to verify in place and are care planned weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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F 689	Continued From page 123 Additional observations of Resident #40 on 7/28/2021 8:41 a.m. and 7/29/2021 at approximately 8:00 a.m. revealed Resident #40 in bed without fall mats beside the bed. The comprehensive care plan for Resident #40 dated 1/9/2020 documented in part, "At risk for falls due to impaired balance/poor coordination. dx (diagnosis) hx (history) CVA (cerebrovascular accident) with hemiplegia. Date Initiated: 01/09/2020." Under "Interventions/Tasks" it documented in part, " ... Fall Matt(s): Bilateral. Date Initiated: 06/02/2020. Revision on: 01/21/2021..." The "Care Conference Note" for Resident #40 dated 3/19/2021 documented in part, "Topics Discussed: Risk for Falls/Safety..." The "Fall Risk Evaluation" for Resident #40 dated 12/4/2020 documented in part, "...Category: High Risk; Score: 11.0" The physician order's for Resident #40 failed to evidence an order for bilateral fall mats. On 7/29/2021 at approximately 7:45 a.m., an interview was conducted with LPN (licensed practical nurse) #5, the MDS coordinator. LPN #5 stated that the nurses updated the care plans in between the admission and quarterly care plan reviews with any falls. LPN #5 stated that staff were not implementing the care plan if fall mats were an intervention on the care plan and they were not in place. On 7/29/2021 at approximately 7:59 a.m., an interview was conducted with RN (registered	F 689		

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F 689	Continued From page 124 nurse) #4, unit manager. RN #4 stated that the nurses used the care plan to determine a resident's daily routine and what their safety level was. RN #4 stated that care plans were updated every three months and any resolved problems were removed or revised and new goals were put into place. RN #4 stated that staff were not implementing the care plan if fall mats were an intervention on the care plan and they were not in place. RN #4 observed Resident #40 in their room in bed without the fall mats in place. On 7/27/2021 at approximately 11:15 a.m., ASM #2, the director of nursing stated that the facility followed their policies and procedures as their nursing standard of practice. On 7/28/2021 at approximately 5:45 p.m., a request was made to ASM (administrative staff member) #1, the regional director of clinical services for the facility policy for implementing the care plan. The facility policy, "Care Plans, Comprehensive Person-Centered" dated December 2016 documented in part, "...The comprehensive, person-centered care plan will: a. Include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being..." On 7/29/2021 at approximately 11:00 a.m., ASM #1, the regional director of clinical services and ASM #2, the director of nursing were made aware of the above concern. No further information was provided prior to exit.	F 689		

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F 689	Continued From page 125 References: 1. Cerebrovascular disease, infarction or accident A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . 2. Hemiplegia Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's	F 690	**F690: Bowel/Bladder Incontinence, Catheter, UTI** 1.Residents #3, #9, and #104 continue to reside in facility and the foley catheters collection bags have been placed below the level of the bladder, are attached to bed/chair/wheelchair as needed to prevent infection risk and there is a Physicians order in place for the Foley catheter.	

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F 690	Continued From page 126 comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure the appropriate care and services for a urinary catheter for three of 49 residents in the survey sample, Residents #3, #9 and #104. 1. The facility staff failed to secure Resident #3's indwelling urinary catheter and failed place the urinary catheter collection bag below the level of the bladder. 2. The facility staff failed to maintain Resident	F 690	2.All residents with foley catheters have the potential to be affected by this alleged deficient practice. Nursing management will audit current residents with foley catheter to verify physician order and observe for placement of foley catheter is below the level of the bladder and has a catheter secure. 3.DON or designee will educate nurses that Residents with Foley Catheters have collection bags and are placed below the level of the bladder, are attached to bed/chair/wheelchair as needed to prevent infection risk and has a Physicians order for the Foley catheter. The foley catheter has a catheter secure. 4.DON or designee will audit Resident's with Foley Catheters weekly times 4 weeks and monthly times 2 to ensure that the foley catheters collection bags have been placed below the level of the bladder, are attached to bed/chair/wheelchair as needed to prevent infection risk and have catheter secure. A Physicians order for the Foley catheter. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months.	

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F 690	Continued From page 127 #9's urinary catheter bag in a manner to prevent infection. The catheter bag was observed lying on the floor during the dates of the survey. 3. The facility staff failed to position Resident # 104's catheter collection bag below the level of their bladder to prevent backflow of urine and failed to obtain a physician's order for a catheter. The findings include: 1. Resident #3 was admitted to the facility with diagnoses that include but were not limited to metabolic encephalopathy (1) and hypertension (2). Resident #3's most recent MDS (minimum data set) assessment, a quarterly assessment with an ARD (assessment reference date) of 7/15/2021 coded Resident #3 as severely impaired for making daily decisions. Section G coded Resident #3 as requiring extensive assistance of one person for toilet use and personal hygiene. Section H coded Resident #3 as having an indwelling catheter. On 7/28/2021 an observation was made of Resident #3 during wound care with LPN (licensed practical nurse) #3, wound nurse. Resident #3 was observed lying in bed positioned in a semi-fowler's position (3). A urinary catheter collection bag was observed on the mattress in the bed with Resident #3. The catheter and bag connection tubing was observed located under Resident #3's left hip/upper posterior thigh. LPN #3 was observed to attempting to place the urinary catheter collection bag on the bed frame and stated that the clip on the bag was missing.	F 690	5.Date of compliance will be August 20, 2021.	

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F 690	Continued From page 128	F 690		

LPN #3 placed the urinary catheter collection bag tubing at the end of the mattress with the bag hanging below. LPN #3 proceeded to provide wound care. Upon staff turning Resident #3 to their right side, observation revealed the urinary catheter was not secured to the resident and had leaked onto the sheets. A small skin indention was visible where the urinary catheter and bag connection tubing were underneath Resident #3's left hip/upper posterior thigh prior to turning.

The physician orders for Resident #3 documented in part,
- "Urinary catheter: urinary retention size: 16FR (french) balloon size: 10 change PRN (as needed) for obstruction. Order Date: 01/20/2021."
- "Change Foley cath [catheter] every 30 days along with Foley bag; size 16 French 10 ml (milliliter) balloon every evening shift every 30 day(s) for to prevent infection. Order Date: 02/16/2021."

The comprehensive care plan for Resident #3 dated 4/22/2021 documented in part, "Use of indwelling urinary catheter related to Stage III or IV pressure ulcer (4). Date Initiated: 04/22/2021."

On 7/28/2021 at approximately 10:30 a.m., an interview was conducted with LPN #3. LPN #3 stated that urinary catheter collection bags should be placed below the level of the bladder. LPN #3 stated that Resident #3's bag did not have a hook to attach it to the bed frame so they had moved it from lying on the mattress beside Resident #3's legs to hang off the end of the mattress until she could replace it. LPN #3 stated that the purpose of hanging the bag below the level of the bladder was to promote gravity drainage and potential

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F 690	Continued From page 129 infection. LPN #3 stated that urinary catheters were anchored by using a special attachment device or by using tape to prevent the catheter from pulling while providing care. LPN #3 stated that Resident #3's catheter was not anchored and that the catheter should be placed between the legs to allow it to drain freely. LPN #3 stated that the catheter should not be located underneath a resident because it could potentially cause a pressure ulcer from laying on it. On 7/28/2021 at approximately 11:21 a.m., an interview was conducted with LPN #7. LPN #7 stated that urinary catheter bags were supposed to hang on the side of the bed to promote urine drainage. LPN #7 stated that a urinary catheter is supposed to be anchored to the inside of the leg to keep from pulling and to prevent it from moving. LPN #7 stated that they had changed the urinary catheter collection bag for Resident #3 after LPN #3 had advised them it did not have a hook for the bed. On 7/27/2021 at approximately 11:15 a.m., ASM #2, the director of nursing stated that the facility follows their policies and procedures as their nursing standard of practice. On 7/28/2021 at approximately 5:45 p.m., a request was made to ASM (administrative staff member) #1, the regional director of clinical services for the facility policy for care of catheters. The facility provided policy, "Catheter Care, Urinary" dated September 2014 documented in part, "...Maintaining Unobstructed Urine Flow. 1. Check the resident frequently to be sure he or she is not lying on the catheter and keep the	F 690		

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F 690	Continued From page 130 catheter and tubing free of kinks. 2. Unless specifically ordered, do not apply a clamp to the catheter. 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder..." The policy further documented, "...Be sure the catheter tubing and drainage bag are kept off the floor...Ensure the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident's inner thigh..." On 7/28/2021 at approximately 5:30 p.m., ASM #1, the regional director of clinical services, ASM #2, the director of nursing and ASM #4, the medical director were made aware of the above concern. No further information was provided prior to exit. References: 1. Encephalopathy is a general term describing a disease that affects the function or structure of your brain. This information is taken from the website https://www.healthline.com/health/hepatic-encephalopathy. 2. Hypertension: High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 3. Semi-fowler's position a position similar to Fowler's POSITION but with the head less elevated. Fowler's position - a position in which	F 690		

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F 690	Continued From page 131 the head of the patient's bed is raised 30 to 90 degrees above the level, with the knees sometimes also elevated. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/semi-Fowler+position 4. Pressure ulcer is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm. 2. Resident #9 was admitted to the facility with diagnoses that include but were not limited to benign prostatic hyperplasia (1) and retention of urine (2). Resident #9's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 4/23/2021 coded Resident #9 as scoring a 13 on the brief interview for mental status (BIMS) scale, 13 - being	F 690		

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F 690	Continued From page 132 cognitively intact for making daily decisions. Section G coded Resident #9 as requiring extensive assistance of one person for toilet use. Section H coded Resident #9 as having an indwelling catheter. On 7/27/2021 at approximately 2:18 p.m., an observation was made of Resident #9 in their bed. Resident #9's urinary catheter collection bag was observed lying on the floor beside the bed. At this time, an interview was conducted with Resident #9. When asked about the urinary catheter collection bag on the floor, Resident #9 stated, "I have so many tubes in me, I can't keep up with them. The nurses take care of them all for me." Additional observations on 7/27/2021 at 3:45 p.m. and 7/28/2021 at 9:24 a.m. revealed Resident #9's urinary catheter collection bag lying on the floor beside the bed. The comprehensive care plan for Resident #9 failed to evidence documentation of an indwelling urinary catheter for Resident #9. The care plan, "Renal insufficiency related to chronic renal failure (3), dx (diagnosis) bph (benign prostatic hyperplasia). Date Initiated: 10/31/2020" failed to evidence documentation of an indwelling urinary catheter for Resident #9. The physician orders for Resident #9 documented in part, - "Catheter output every shift. Order Date: 05/06/2021." - "Change Foley (catheter) bag PRN (as needed). Order Date: 01/22/2021." - "Urinary catheter: Hydronephrosis (4) with renal and ureteral calculous [sic] (5) obstruction size:	F 690		

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F 690	Continued From page 133 166[sic] FR (french) balloon size 10 cc (cubic centimeters) change PRN for obstruction. Order Date: 7/26/2021." On 7/28/2021 at approximately 10:30 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that urinary catheter collection bags should be placed below the level of the bladder. LPN #3 stated that the urinary catheter collection bag should be hooked onto the side of the bed to promote gravity drainage. On 7/28/2021 at approximately 11:21 a.m., an interview was conducted with LPN #7. LPN #7 stated that urinary catheter bags were supposed to hang on side of the bed to promote urine drainage. LPN #7 stated that urinary catheter collection bags were not supposed to be on the floor because it was unsanitary. LPN #7 observed Resident #9's urinary catheter collection bag on the floor beside their bed and stated that it should be hooked onto the bed. On 7/28/2021 at approximately 5:30 p.m., ASM #1, the regional director of clinical services, ASM #2, the director of nursing and ASM #4, the medical director were made aware of the above concern. No further information was provided prior to exit. References: 1. Benign prostatic hyperplasia: An enlarged prostate is also called benign prostatic hyperplasia (BPH). This information was obtained from the website: https://medlineplus.gov/enlargedprostatebph.html	F 690		

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F 690	Continued From page 134 2. Urinary retention is a condition in which you cannot empty all the urine from your bladder. This information was obtained from the website: https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention 3. Chronic kidney disease: Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. 4. Hydronephrosis is the swelling of a kidney due to a build-up of urine. It happens when urine cannot drain out from the kidney to the bladder from a blockage or obstruction. Hydronephrosis can occur in one or both kidneys. This information was obtained from the website: https://www.kidney.org/atoz/content/hydronephrosis 5. Renal calculus: Kidney stones (also called renal stones or urinary stones) are small, hard deposits that form in one or both kidneys; the stones are made up of minerals or other compounds found in urine. This information was obtained from the website: https://medlineplus.gov/genetics/condition/kidney-stones/ 3. Resident # 104 was admitted to the facility with diagnoses that included but were not limited to: Parkinson's disease [1] and multiple sclerosis [2]. Resident # 104's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 07/08/2021, coded Resident # 104 as scoring an 11 on the	F 690		

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F 690	Continued From page 135 brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Resident # 18 was coded as requiring extensive assistance of one staff member for activities of daily living. Under section H "Bladder and Bowel" Resident # 104 was coded under "H0100" as having an indwelling catheter and an external catheter. On 07/27/21 at 11:45 a.m., at 1:05 p.m and at 2:05 p.m., observations of Resident # 104 revealed the resident sitting in their power wheelchair. Observations of the wheelchair revealed the catheter collection bag was hanging on the front of the control arm of power wheelchair. Further observations of the catheter collection bag revealed that it was at the height of Resident # 104's navel while they were sitting in their wheelchair. Observations of the catheter tubing revealed that it was draped over Resident # 104's thighs, then rose over the arm of the wheelchair and into the collection bag. On 07/28/21 at 1:30 p.m., an observation of Resident # 104 revealed they were sitting in their power wheelchair. Observation of the wheelchair revealed the catheter collection bag was hanging on the front of the control arm of power wheelchair. Further observation of the catheter collection bag revealed that it was at the height of Resident # 104's navel while they were sitting in their wheelchair. Observation of the catheter tubing revealed that it was draped over Resident # 104's thighs, then rose over the arm of the wheelchair and into the collection bag. The POS [physician's order sheet] for Resident # 104 dated 07/28/2021 documented, "Urinary Catheter: Condom change PRN [as needed] if	F 690		

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F 690	Continued From page 136 obstructed. Order Date: 07/28/2021." The comprehensive care plan for Resident # 104 dated 07/05/2021 failed to evidence documentation to address Resident # 104's condom catheter. On 07/27/21 at 12:50 p.m., an interview was conducted with Resident # 104. When asked who placed the catheter collection bag on the arm of the wheelchair Resident # 104 stated, "The nurse." On 07/28/2021 at 3:12 p.m. an interview was conducted with LPN [licensed practical nurse] # 3, unit manager. LPN #3 was informed of the above observations of Resident # 104's catheter collection bag and tubing LPN # 3 stated that the collection bag and tubing was positioned to high and would cause backflow of urine into the bladder. When asked if there was a physician's order for Resident # 104's catheter, LPN # 3 reviewed the electronic physician's order sheet on the computer. After reviewing the orders LPN # 3 stated that Resident # 104 was admitted with the catheter and an order should have been obtain at the time of their admission. On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A type of movement disorder. This information was obtained from the website:	F 690		

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F 690	Continued From page 137 https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. [2] A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html.	F 690		
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, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory services per the physician orders and per the comprehensive care plan for three of 49 residents in the survey sample, Residents #172, #171 and #11. The findings include: 1. a. Resident #172 was admitted to the facility on 6/16/2021 with diagnoses that included but were not limited to: chronic obstructive pulmonary	F 695	**F695: Respiratory/Tracheostomy Care and Suctioning** 1.Residents #172, #171 and #11 continue to reside in facility and verification that residents have: - have appropriate supplies (i.e., ambubag, back up trach, and suctioning kit) readily available at the bedside. - Equipment Masks (Bipap, Cpap, Nebulizer) are kept in a clean/appropriate bag for infection control and storage - Residents on oxygen have the oxygen set appropriately per MD order 2.All residents requiring Respiratory/Tracheostomy care and suctioning have the potential to be affected by this alleged deficient practice. Nursing management will audit current residents with oxygen, trach and suctioning to verify:	

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F 695	Continued From page 138 disease (COPD) (1), high blood pressure, diabetes and morbid obesity (overweight). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/22/2021, coded Resident #172 as scoring a "2" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living except eating in which she was coded as requiring supervision after set up assistance was provided. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as using oxygen and having a Non-invasive Mechanical Ventilator while a resident at the facility. On 7/27/2021 at 11:40 a.m., observation revealed, Resident #172 in her bed with her oxygen on via a nasal cannula (a two-prong tube that inserts into the nose), that was connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set at 4.5 LPM (liters per minute). Further observation revealed the oxygen concentrator was out of Resident #172's reach. On 7/28/2021 at 8:07 a.m., a second observation revealed Resident 172 in her bed with the oxygen on via a nasal cannula that was connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set with the bottom of the ball on the 5 LPM line. An observation was made of Resident #172 on 7/28/2021 at 12:07 p.m., with LPN (licensed practical nurse) #6. When asked to read the	F 695	- have appropriate supplies (i.e., ambubag, back up trach, and suctioning kit) readily available at the bedside. - Equipment Masks (Bipap, Cpap, Nebulizer) are kept in a clean/appropriate bag for infection control and storage - Residents on oxygen have the oxygen set appropriately per MD order. 3.DON or designee will educate Nursing Staff on standards of care for suctioning and oxygen related to Respiratory and Tracheostomy Residents to include: - having appropriate supplies (i.e., ambubag, back up trach, and suctioning kit) readily available at the bedside. - Equipment Masks (Bipap, Cpap, Nebulizer) are kept in a clean/appropriate bag for infection control and storage - Residents on oxygen have the oxygen set appropriately per MD order 4.DON or designee will audit residents with Respiratory/Tracheostomy to verify that standards of care to include:	

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F 695	Continued From page 139 resident's oxygen concentrator, LPN #6 stated, "Oh Lord. I believe she is supposed to be on 3 LPM. LPN #6 proceeded to check the resident's order on the computer and verified the resident was supposed to be on 3 LPM. The physician order dated, 7/2/2021, documented, "Oxygen at 3 liters/minute via nasal cannula every shift." Resident #172's TAR (treatment administration record) for July 2021 documented the above physician order. Further review revealed documentation the oxygen was administered as ordered on 7/27/2021 for the day shift and for the day shift on 7/28/2021, there was no documentation for the administration of oxygen, the area for staff initials was blank. The comprehensive care plan dated, 6/25/2021, documented in part, "Focus: Has/at risk for respiratory impairment related to COPD and acute and chronic respiratory failure." The "Interventions/Tasks" documented, "Administer oxygen per physician order." The facility policy, "Oxygen Administration" documented in part, "1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration...Steps in the Procedure: .. 8. Turn on oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute." ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 p.m.	F 695	- have appropriate supplies (i.e., ambubag, back up trach, and suctioning kit) readily available at the bedside. - Equipment Masks (Bipap, Cpap, Nebulizer) are kept in a clean/appropriate bag for infection control and storage - Residents on oxygen have the oxygen set appropriately per MD order weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 24, 2021.	

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F 695	Continued From page 140 No further information was provided prior to exit. References: (1) COPD or chronic obstructive pulmonary disease-general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 1.b. The facility staff failed to store a BiPap (Bi - PAP, bi-level Positive Airway Pressure (1)), mask and tubing in a sanitary manner for Resident # 172. On 7/27/2021 at 11:40 a.m., observation revealed Resident #172 in her bed. An uncovered BiPap mask and tubing were sitting on the resident's night stand top. On 7/28/2021 at 8:07 a.m., a second observation revealed, the BiPap mask and tubing sitting on top of the nightstand, not covered in any manner. On 7/28/2021, at 12:07 p.m., an observation was made of Resident #172 with LPN (licensed practical nurse) #6. When asked about the above uncovered items observed on the residents night stand, LPN #6 stated it was a BiPap mask and it should be stored in a plastic bag. When asked why it should be stored in a plastic bag, LPN #6 stated to keep it clean and to prevent infection. An interview was conducted with LPN # 3, the unit manager, on 7/28/2021 at 2:32 p.m. When asked how a BiPap mask and tubing should be stored when not in use, LPN #3 stated it should be cleaned, taken apart, stored separately to dry.	F 695		

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F 695	Continued From page 141 When asked if the mask should be uncovered and sitting on the nightstand, LPN #3 stated, "No, that is an infection control concern." The facility policy, "CPAP/BiPAP Support" documented in part, "General Guidelines for Cleaning ... 7. Masks, nasal pillows and tubing: Clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow it to air dry between uses." The facility policy failed to evidence documentation regarding the storage of the BiPAP when not in use. ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 p.m. No further information was provided prior to exit. References: (1) BiPap - Bi - PAP, bi-level Positive Airway Pressure), mask and tubing in a sanitary manner for Resident # 172 is a machine used to assist people who are diagnosed with sleep apnea. Bi Pap machine can be set for breathing in and breathing out pressure settings. This information was obtained from the following website: https://medlineplus.gov/ency/article/001916.htm. 2. The facility staff failed to administer oxygen to Resident #171 per the physician order. Resident #171 was admitted to the facility on 7/14/2021 with diagnoses that included but were not limited to: Cancer of the esophagus (the	F 695		

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F 695	Continued From page 142 muscular canal that transports food from the mouth to the stomach) (1), Bipolar Disorder (a mental disorder characterized by episodes of mania and depression) (2), and muscle weakness. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 7/20/2021, coded Resident #171 as scoring a "14" 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 having used oxygen while a resident at the facility. On 7/27/2021 at 11:30 a.m., observation revealed Resident #171 lying in his bed with oxygen in use via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set with the bottom of the ball sitting on the line for 2 LPM (liters per minute). On 7/28/2021 at 9:04 a.m., a second observation revealed Resident #171 was lying in his bed. He had oxygen in use via nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set with the bottom of the ball sitting on the line for 2 LPM. On 7/28/2021 at 12:36 p.m. an observation made with LPN (licensed practical nurse) #6, revealed Resident #171 with oxygen in use via the nasal cannula connected to an oxygen concentrator that was running. LPN #6 was asked the flow rate setting of the resident's oxygen concentrator. LPN #6 stated, "Almost 3 LPM." When asked how to read the oxygen concentrator for the	F 695		

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F 695	Continued From page 143	F 695		

prescribed rate, LPN #6 stated the line for the prescribed rate should be through the center of the ball.

The physician order dated 7/22/2021 documented, "Oxygen at 2 liters/minute via nasal cannula every shift."

Review of Resident #171's "Treatment Administration Record" for July 2021 documented the above physician order for oxygen. Further review of the TAR revealed documentation the oxygen was administered per the physician order for the day shift on 7/27/2021 and 7/28/2021.

The comprehensive care plan, dated, 7/27/2021, documented, "Focus: Has/at risk for respiratory impairment related to esophageal cancer." The "Interventions" documented in part, "Administer oxygen per physician order."

An interview was conducted with LPN #3, the unit manager, on 7/28/2021 at 2:32 p.m. When asked how to read the oxygen concentrator to set the resident's prescribed oxygen flow rate, LPN #3 stated the nurse has to get down to eye level. When asked where the ball should be, LPN #3 stated the line should be between the ball, not on the top or bottom, in the middle of the ball.

The manufacturer's manual for Resident #171's oxygen concentrator, documented in part, "1. Turn the flowrate knob to the setting prescribed by your physician or therapist. To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liters per minute) line prescribed."

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F 695	Continued From page 144 ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above findings on 7/28/2021 at 5:07 p.m. No further information was provided prior to exit. (1) Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 208. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72. 3. The facility staff failed to ensure tracheostomy care was provided to Resident #11 per the physicians orders. A. the facility staff failed maintain an Ambu bag [1] at Resident # 11's bed side according to physician's orders. Resident # 11 was admitted to the facility with diagnoses that include but not limited to: skin cancer of scalp and neck, respiratory failure with hypoxia [2], acquired absence of larynx [3] and tracheostomy [4]. Resident # 11's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/27/2021, coded Resident # 11 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 14 - being cognitively intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 11 for "Tracheostomy care" while a resident. The physician's order dated 04/01/2021 for	F 695		

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F 695	Continued From page 145 Resident # 11 documented, "Keep a spare trach and ambu bag with pt [patient] at all times." The physician's order for Resident # 11 documented, "Keep a spare lary tube [5] and ambu bag with pt [patient] at all times. Revision Date: 07/28/2021." The comprehensive care plan for Resident # 11 dated 04/21/2021 failed to evidence interventions addressing Resident #11's care needs for tracheostomy care. On 07/27/21 at 2:00 p.m., on 07/28/21 at 8:02 p.m., on 07/28/21 at 10:15 a.m., and at 11:50 a.m., observations of Resident # 11's room failed to evidence an ambu bag. On 07/28/21 at approximately 11:50 a.m., an observation of Resident # 11's room was conducted with LPN [licensed practical nurse] # 1. LPN #1 was asked to locate the ambu bag for Resident # 11. LPN # 2 looked inside the closet and the bedside table and stated that it wasn't in the room. When asked if they were aware of the physician's order for the ambu bag, LPN # 1 stated no. On 07/29/2021 at 8:25 a.m., an interview was conducted with RN [registered nurse] # 2, assistant director of nursing. When asked about the two physician's orders above, RN # 2 stated that they only changed the term "Trach" to "Lary tube" because it was a better description of the type of device Resident # 11 actually had. When asked to describe the difference between the two RN # 2 stated, "Lary tube is one whole tube where the trach tube has a separate inner cannula."	F 695		

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F 695	Continued From page 146 On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, regional director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A self-refilling bag-valve-mask unit with a 1 -1.5 litre capacity, used for artificial respiration which, while suboptimal for the non-intubated patient, is effective for ventilating and oxygenating intubated patients, allowing both spontaneous and artificial respiration. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/Ambu+bag [2] 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. Hypoxia - Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia. [3] The larynx, or voice box, is located in the neck and performs several important functions in the body. The larynx is involved in swallowing, breathing, and voice production. This information was obtained from the website: https://medlineplus.gov/ency/imagepages/19708.htm.	F 695		

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F 695	Continued From page 147 [4] A surgical procedure to create an opening through the neck into the trachea (windpipe). A tube is most often placed through this opening to provide an airway and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.. This information was obtained from the website: https://medlineplus.gov/ency/article/002955.htm. [5] A lary tube is a flexible silicone tube designed to maintain the stoma right after the laryngectomy surgery. A lary tube is used to maintain the airway and can be following a laryngectomy. This information was obtained from the website: https://patientslearn.uams.edu/wp-content/uploads/sites/95/2018/03/Lary_Tube_Care.pdf B. The facility staff failed to clean Resident # 11's the tracheostomy inner cannula [1] according to the physician's orders. The POS [physician's order sheet] for Resident # 11 dated 04/21/2021 documented, "Cleanse inner cannula daily to prevent build up, Trach [tracheostomy] dressing daily, and keep area dry to prevent further skin breakdown. One (Sic.) time a day for Trach care Change trach dressing and inner cannula daily -Order Date: 04/21/2021. The eTAR [electronic treatment administration record] dated July 2021 for Resident #11, documented the above physician's order. Further review of the eTAR revealed blanks on 07/11/21, 07/12/21, 07/16/21 and on 07/17/21. On 07/28/21 at 11:33 a.m., an interview was conducted with LPN [Licensed practical nurse] # 3, unit manager, regarding the blanks on	F 695		

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F 695	Continued From page 148 Resident # 11's eTAR. After LPN # 3 reviewed the eTAR, LPN # 3 stated, "If it wasn't documented it wasn't done." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, regional director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] The inner cannula is an inner tube inserted within the main outer cannula of the tracheostomy tube and is useful for individuals who require secretion management. The inner cannula reduces the diameter of the tracheal tube lumen, increasing resistance and work of breathing. This information was obtained from the website: https//www.tracheostomyeducation.com C. The facility staff failed to document the presence of a suction catheter [1] for Resident # 11's tracheostomy care according to the physician's orders. The POS [physician's order sheet] for Resident # 11 dated 04/21/2021 documented, "14 FR [French] Suction Catheter every shift for Tracheostomy care -Start Date: 05/14/2021." The eTAR [electronic treatment administration record] dated July 2021 for resident #11, documented the above physician's order. Further review of the eTAR revealed blanks on 07/06/21, 07/11/21, 07/12/21, 07/16/21 and on 07/17/21 on the 7:00 a.m. to 3:00 p.m. shift; 07/03/21, 07/11/21, 07/19/21, 07/23/21, 07/26/21 and on	F 695		

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F 695	Continued From page 149 07/28/21 on the 3:00 p.m. to 11:00 p.m. shift; 07/02/21, 07/10/21 and on 07/24/21 on the 11:00 p.m. to 7:00 a.m. shift. On 07/28/21 at 11:33 a.m., an interview was conducted with LPN [Licensed practical nurse] # 3, unit manager, regarding the blanks on Resident # 11's eTAR. After LPN # 3 reviewed the eTAR, LPN # 3 stated, "If it wasn't documented it wasn't done." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, regional director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1]A catheter used to remove mucus and other secretions from the upper airway, trachea, and main bronchi. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/suction+catheter D. The facility staff failed to document the supply of humidified air [moist air] for Resident # 11's tracheostomy care according to the physician's orders. The POS [physician's order sheet] for Resident # 11 dated 04/21/2021 documented, "Humidified air for new stoma every shift for tracheostomy care-Start Date: 05/14/2021." The eTAR [electronic treatment administration	F 695		

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F 695	Continued From page 150 record] dated July 2021, for Resident #11, documented the physician's order as stated above. Further review of the eTAR revealed blanks on 07/06/21, 07/11/21, 07/12/21, 07/16/21 and on 07/17/21 on the 7:00 a.m. to 3:00 p.m. shift; 07/03/21, 07/11/21, 07/19/21, 07/23/21, 07/26/21 and on 07/28/21 on the 3:00 p.m. to 11:00 p.m. shift; 07/02/21, 07/10/21 and on 07/24/21 on the 11:00 p.m. to 7:00 a.m. shift. On 07/28/21 at 11:33 a.m., an interview was conducted with LPN [Licensed practical nurse] # 3, unit manager, regarding the blanks on Resident # 11's eTAR. After LPN # 3 reviewed the eTAR, LPN # 3 stated, "If it wasn't documented it wasn't done." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, regional director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. e. The facility staff failed to document the compressor setting of 28% for Resident # 11's tracheostomy care according to the physician's orders. The POS [physician's order sheet] for Resident # 11 dated 04/21/2021 documented, "Oxygen compressor setting 28% via trach collar. every shift for Hypoxia Oxygen Compressor settings 28% via trach collar -Start Date: 04/21/2021." The eTAR [electronic treatment administration record] dated July 2021, for Resident #11, documented the above physician's order. Further	F 695		

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F 695	Continued From page 151 review of the eTAR revealed blanks on 07/06/21, 07/11/21, 07/12/21, 07/16/21 and on 07/17/21 on the 7:00 a.m. to 3:00 p.m. shift; 07/03/21, 07/11/21, 07/19/21, 07/23/21, 07/26/21 and on 07/28/21 on the 3:00 p.m. to 11:00 p.m. shift; 07/02/21, 07/10/21 and on 07/24/21 on the 11:00 p.m. to 7:00 a.m. shift. On 07/28/21 at 11:33 a.m., an interview was conducted with LPN [Licensed practical nurse] # 3, unit manager, regarding the blanks on Resident # 11's eTAR. After LPN # 3 reviewed the eTAR, LPN # 3 stated, "If it wasn't documented it wasn't done." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. f. The facility staff failed to document the presence of a Yankaur [1] suction catheter for Resident # 11's tracheostomy care according to the physician's orders. The POS [physician's order sheet] for Resident # 11 dated 04/21/2021 documented, "Yankaur suction catheter every shift for Tracheostomy care -Start Date: 05/14/2021." The eTAR [electronic treatment administration record] dated July 2021 documented the physician's order as stated above. Further review of the eTAR revealed blanks on 07/06/21, 07/11/21, 07/12/21, 07/16/21 and on 07/17/21 on the 7:00 a.m. to 3:00 p.m. shift; 07/03/21,	F 695		

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F 695	Continued From page 152 07/11/21, 07/19/21, 07/23/21, 07/26/21 and on 07/28/21 on the 3:00 p.m. to 11:00 p.m. shift; 07/02/21, 07/10/21 and on 07/24/21 on the 11:00 p.m. to 7:00 a.m. shift. On 07/28/21 at 11:33 a.m., an interview was conducted with LPN [Licensed practical nurse] # 3, unit manager, regarding the blanks on Resident # 11's eTAR. After LPN # 3 reviewed the eTAR, LPN # 3 stated, "If it wasn't documented it wasn't done." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, regional director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] A rigid hollow tube made of metal or disposable plastic with a curve at the distal end to facilitate the removal of thick pharyngeal secretions during oral pharyngeal suctioning. This information was obtained from the website: https://medical-dictionary.thefreedictionary.com/Yankauer+suction+catheter.	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	F 698	**F698: Dialysis** 1.Residents #64, #80 and #52 continue to reside in facility and have appropriate orders for dialysis, dialysis AV shunt being assessed each shift, and accurate communication to and from the dialysis center. Residents #114, #173, and #59 have been discharged from the facility.	

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F 698	Continued From page 153 by: Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined the facility staff failed to provide care and services related to dialysis for six of 49 residents in the survey sample, Residents #64, #114, #173, #80, #59, and #52. The facility failed to ensure an ongoing communication process with the dialysis centers for Resident #64, #114, #173, #80, #59 and #52, and failed to have a physician order for Resident #173 to receive dialysis, failed to ensure Resident #80's dialysis AV [arteriovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders. The findings include: 1. The facility staff failed to have a communication process with the dialysis center for Resident #64. Resident #64 was admitted to the facility on 6/10/2021 with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), depression and gastroesophageal reflux disease (backflow of the contents of the stomach into the esophagus) (2). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/17/2021, coded Resident #64 as scoring a "10" on the BIMS (brief interview for mental status) score indicating the	F 698	2.All residents requiring Dialysis treatments have the potential to be affected by this alleged deficient practice. Nursing management will audit current resident's receiving dialysis to verify physician orders for dialysis, assessing dialysis site with documentation. Audit the dialysis communication book documentation has been reviewed to and from dialysis . 3.DON or designee will educate Nursing Staff on obtaining dialysis orders, dialysis AV shunt being assessed each shift and documentation for communication to and from the dialysis center for all resident receiving outside Dialysis treatments. 4.DON or designee will audit residents receiving dialysis treatments to verify has dialysis orders per physician , the dialysis AV shunt is being assessed each shift with documentation, and communication to and from the dialysis centers are documented and reviewed weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months.	

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F 698	Continued From page 154 resident was moderately impaired to make daily cognitive decisions. In Section O - Special Treatments, Procedures, and Programs, Resident #64 was coded as receiving dialysis while a resident at the facility. The physician order dated, 6/15/2021, documented, "Hemodialysis Dialysis Days and Time: MON (Monday), WED (Wednesday) FRIDAY Dialysis Center (name of dialysis center) phone # (phone number for the dialysis center). The dialysis communication book for Resident #64 was located in the chart rack behind the nurse's station. The sheets in the book documented the date, vital signs, and a space for notes to the dialysis center from the facility and a place for the dialysis center to communicate with the facility. There was documentation in Resident #64's dialysis communication book for the following dates: 6/11/2021, 6/14/2021, 6/16/2021, 6/18/2021, 6/21/2021, 6/23/2021, 6/25/2021, 6/28/2021, 6/30/2021, 7/2/2021, 7/7/2021, 7/9/2021, 7/14/2021, and 7/26/2021. Based on the physician orders for dialysis on Monday, Wednesday, and Friday, the following dates were dialysis dates and were missing documentation: 7/5/2021, 7/12/2021, 7/16/2021, 7/19/2021, 7/21/2021, and 7/23/2021. Review of facility's nurse's notes for June and July 2021, for Resident #64 failed to evidence documentation that the facility staff provided ongoing communication regarding Resident # 64 to the dialysis center staff The comprehensive care plan dated, 7/1/2021, documented in part, "Focus: Renal insufficiency related to ESRD (end stage renal disease) with	F 698	5.Date of compliance will be August 20, 2021.	

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F 698	Continued From page 155 HD (hemodialysis)." The "Interventions/Tasks" documented, "Administer medications per physician order. Arrange for transportation to and from dialysis center on dialysis days. Check access site for lack of thrill/bruit, evidence of infection, swelling or excessive bleeding per facility guidelines. Report abnormalities to physician. Diet per physician orders." An interview was conducted with LPN (licensed practical nurse) #1 on 7/28/2021 at 12:30 p.m. LPN #1 was asked to explain the process staff follows for a resident going to dialysis, LPN #1 stated, "We send the book with him. They (dialysis center) are supposed to put things in them (the dialysis communication book)." When asked if she was supposed to document anything in the dialysis communication book, LPN #1 stated, "My understanding is to put anything unusual so they are aware. We get communication regarding his Vancomycin (an antibiotic used to treat serious infections) (3) that they (dialysis center) administer." When asked if the book should is sent with Resident #64 for every dialysis day ordered, LPN #1 stated, "If the book doesn't go a sheet should go. If there is no communication in the book, it wasn't sent or it never came back from dialysis." An interview was conducted with LPN #3, the unit manager, on 7/28/2021 at 2:22 p.m. When asked about the process staff follows for a resident going to dialysis, LPN #3 stated, "Before the resident leaves the staff should get a set of vital signs (blood pressure, temperature, pulse and oxygen saturation). Each dialysis resident has a book and there are sheets in the book that the vital signs are written on. The book accompanies the resident to dialysis. When the resident returns	F 698		

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F 698	Continued From page 156	F 698		

from dialysis, the book is looked at to see if there is any communication from the dialysis center to us (facility), if new medications, orders, pre and post set of vital signs and weights. The nurse should note off on it." When asked where the sheets are kept, LPN #3 stated in the binder for each individual resident. If they (dialysis communication sheets) are not in the book we should call the dialysis center to get it from them." LPN #3 was asked to find any of the missing sheets for the dates missing communication as documented above.

On 7/29/2021 at 11:30 a.m., LPN #3 stated she could not find any of the missing dialysis communication sheets.

The facility policy, "End-Stage Renal Disease, Care of a Resident with," documented in part, "Resident with end-stage renal disease (ESRD) will be care for according to currently recognized standards of care. 4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: How the care plan will be developed and implemented, how information will be exchanged between the facility."

ASM (administrative staff member) #1, the regional director of clinical services and ASM #2, the director of nursing, were made aware of the above concern on 7/29/2021 at 10:41 a.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 266.

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F 698	Continued From page 157 (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601167.html. 2. The facility staff failed to have a communication process with the dialysis center for Resident #114. Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, coded Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as having received dialysis while a resident in the facility.	F 698		

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F 698	Continued From page 158 The physician order dated, 6/10/2021, documented, "Hemodialysis Diagnosis: ESRD dialysis days and time: MON, WED, FRIDAY, pick up time: 3:00 p.m. (name of dialysis center) (phone number of dialysis center) Transport Company: resident personal driver one time a day every Mon, Wed, Fri [Monday, Wednesday, Friday]." The dialysis communication book for Resident #114 was located in the chart rack behind the nurse's station. The sheets in the book documented the date, vital signs, and a space for notes to the dialysis center from the facility and a place for the dialysis center to communicate with the facility. There was documentation in Resident #64's dialysis communication book for the following dates: 7/2/2021, 6/25/2021, 6/16/2021, 6/14/2021, 6/11/2021, 6/9/2021, 6/7/2021, 6/4/2021, and 6/2/2021. Based on the physician's order above, for dialysis every Monday, Wednesday, and Friday the following dialysis dates were missing documentation: 5/28/2021, 6/21/2021, 6/23/2021, 6/28/2021, 7/16/2021, 7/19/2021, 7/21/2021 and 7/26/2021. Review of facility's nurse's notes for June and July 2021, for Resident #114 failed to evidence documentation that the facility staff provided ongoing communication regarding Resident # 114 to the dialysis center staff The comprehensive care plan dated 6/25/2021, documented in part, "Focus: renal insufficiency related to dependence on renal dialysis." The "Interventions/Tasks" documented in part, "Arrange transportation to and from dialysis center on Mon, Wed, Fri. Pick up time. (Number of phone number of dialysis center) Transport	F 698		

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F 698	Continued From page 159 company: Resident personal driver. Coordinate dialysis care with the dialysis treatment center. Dialysis: hemodialysis diagnosis: ESRD Dialysis days and time: Mon, Wed, Fri. Pick up time: 3:00 p.m. (name and address of dialysis center) (phone number of dialysis center) Transport company: resident personal driver." An interview was conducted with LPN #6 (licensed practical nurse) on 7/28/2021 at 12:14 p.m. When asked about the process followed when Resident #114 is sent to dialysis, LPN #6 stated she sends a brown bag snack and the communication book. When asked what's in the book, LPN #6 stated the top of the form list the vital signs, changes in the resident's condition, and medications given. LPN #6 stated the bottom of the form dialysis center will fill out. When asked if there should be a sheet with communication every time the resident goes to dialysis, LPN #6 stated, yes, the sheets are in the book. An interview was conducted with LPN #3, the unit manager, on 7/28/2021 at 2:22 p.m. When asked about the process staff follows for a resident going to dialysis, LPN #3 stated, "Before the resident leaves the staff should get a set of vital signs (blood pressure, temperature, pulse and oxygen saturation). Each dialysis resident has a book and there are sheets in the book that the vital signs are written on. The book accompanies the resident to dialysis. When the resident returns from dialysis, the book is looked at to see if there is any communication from the dialysis center to us (facility), if new medications, orders, pre and post set of vital signs and weights. The nurse should note off on it." When asked where the sheets are kept, LPN #3 stated in the binder for	F 698		

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each individual resident. If they (dialysis communication sheets) are not in the book we should call the dialysis center to get it from them." LPN #3 was asked to find any of the missing sheets for the dates missing communication as documented above.

On 7/29/2021 at 9:07 a.m., LPN #3 stated she could not find any of the missing days.

ASM (administrative staff member) #1, the regional director of clinical services, and ASM #2, the director of nursing, were made aware of the above concern on 7/28/2021 at 5:07 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 266.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 43.

3. The facility staff failed to obtain a physician order for dialysis and failed to have a communication process with the dialysis center for Resident # 173.

Resident #173 was admitted to the facility on 12/09/2020 with a readmission on 12/26/2020 with diagnoses that included but were not limited to: end-stage renal disease requiring hemodialysis, atrial fibrillation (a condition characterized by rapid and random contraction of

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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 698	Continued From page 161 the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1), high blood pressure, and gastroesophageal reflux disease. The most recent MDS (minimum data set) assessment, a Medicare five day assessment/discharge assessment reference date of 12/28/2020 coded Resident #173 as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section O - Special Treatments, Procedures and Programs, coded the resident as receiving dialysis while a resident as the facility. The review of the physician orders for the time the resident was in the facility, failed to evidence a physician order for dialysis for Resident #173. Review of the clinical record failed to evidence any communication with the dialysis center for Resident #173. An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 7/29/2021 at 8:02 a.m. When asked if a physician order is needed when a resident goes to dialysis, ASM #2 stated, "Yes." ASM #2 was asked to review Resident #173's clinical record for a physician's order for dialysis. ASM #2 reviewed the clinical record and stated, "I do not see a dialysis order." When asked about the location of dialysis communication for Resident #173, ASM #2 stated, "I couldn't find them in the clinical record." ASM #2 was made aware of the above concern	F 698		

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F 698	Continued From page 162 on 7/29/2021 at 8:15 a.m. No further information was provided prior to exit. COMPLAINT DEFICIENCY References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. 4a. The facility staff failed to ensure Resident #80's dialysis AV [arteriovenous] shunt was assessed and checked for a Bruit and Thrill every shift according to the physician's orders. Resident # 80 was admitted to the facility with diagnoses included but were not limited to end stage kidney disease [1], heart disease and stroke. Resident # 80's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/22/2021, coded Resident # 80 as scoring a nine [9] on the brief interview for mental status (BIMS) of a score of 0 - 15, nine - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 80 for "Dialysis" while a resident. The POS [physician's order sheet] for Resident # 80 documented, "Dialysis: Site of AV [arteriovenous] shunt Check Bruit [3] and Thrill [4] every shift. Start Date: 05/12/2021." The eTAR [electronic treatment administration record] for Resident # 80 dated June 2021 documented the above physician's order. Further	F 698		

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F 698	Continued From page 163 review of the eTAR failed to evidence Resident # 80's bruit and thrill was checked on 06/05/21 and 06/06/21 on the 3:00 p.m. to 11:00 p.m. shift; 06/09/21, 06/12/21, 06/13/21, 06/17,21, 06/18/21 and on 06/26/21 on the 11:00 p.m. to 7:00 a.m. shift. The eTAR [electronic treatment administration record] for Resident # 80 dated July 2021 documented the above physician's order. Further review of the eTAR failed to evidence Resident # 80's bruit and thrill was checked on 07/04/21 and 07/05/21, 07/10/21, 07/12/21, 07/16/21, 07/21/21, 07/25/21 on the 3:00 p.m. to 11:00 p.m. shift; 07/04/21, 07/11/21, 07/16/21, and on 07/22,21 on the 11:00 p.m. to 7:00 a.m. shift. The facility's progress notes for Resident # 80 dated 06/01/21 through 07/27/2021 failed to evidence documentation that Resident # 80 bruit and thrill was check on the dates and times listed above on the eTARs for June and July 2021. On 07/28/21 at 11:33 a.m., an interview was conducted with LPN [licensed practical nurse] # 3, unit manager. After reviewing Resident # 80's eTARs dated June and July 2021, LPN # 3 was asked about the blanks on the on the dates and times listed above. LPN # 3 stated, "If it wasn't documented it wasn't done." According to the facility's "End-Stage Renal Disease, Care of a Resident With" revised September 2010, documents in part, "How information will be exchanged between the facilities." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of	F 698		

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F 698	Continued From page 164 clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. References: [1] 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. [2] 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. [3] & [4] There are two signs that indicate a dialysis access site is functioning well. When you slide your fingertips over the site you should feel a gentle vibration, which is called a "thrill." Another sign is when listening with a stethoscope a loud swishing noise will be heard called a "bruit." If both of these signs are present and normal, the graft is still in good condition. This information was obtained from the website: https://www.vascularhealthclinics.org/institutes-divisions/vascular-surgery-and-medicine/dialysis-access/ 4b. The facility staff failed to maintain ongoing communication regarding Resident #80's care with the dialysis center in April 2021, May 2021 and June 2021.	F 698		

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F 698	Continued From page 165 The POS [physician's order sheet] for Resident # 80 documented, "Hemodialysis [2] Diagnosis: ESRD Dialysis Days and Time: Tuesday, Thursday and Saturday Pick up time: 9am Dialysis Center: [Name of Dialysis Center]. Start Date: 05/13/2021." The comprehensive care plan for Resident #80's dated 06/10/2020 documented in part, "Renal insufficiency related to chronic renal failure, presence of fistula/graft/catheter. Date Initiated: 04/16/2021." Under "Interventions/Tasks" Dialysis three x's [times] a week at [Name of Dialysis Center and Address], Thursday, Thursday and Saturday. Date Initiated: 04/16/2021." Review of facility's nurse's notes dated 04/10/2021 through 07/03/2021 failed to evidence documentation that the facility staff provided ongoing communication regarding Resident # 80 to the dialysis center staff on 04/10/21, 04/17/21, 04/20/21, 05/01/21, 05/08/21, 05/11/21, 05/18/21, 06/26/21, 06/28/21 and on 07/03/21. Review of Resident # 80's dialysis communication book failed to evidence documentation from the facility staff to the dialysis center on 04/10/21, 04/17/21, 04/20/21, 05/01/21, 05/08/21, 05/11/21, 05/18/21, 06/26/21 and on 06/28/21. Further review of Resident # 80's dialysis communication book revealed a blank dialysis communication forms that contained sections for the facility staff to document Resident # 80's temperature, pulse, respiration, blood pressure, last pain medication given and what time. On 07/28/21 11:13 a.m., an interview was	F 698		

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F 698	Continued From page 166 conducted with LPN [licensed practical nurse] # 2 regarding the procedure for a resident's dialysis communication forms. LPN # 2 stated, "We fill out the communication sheet for each visit." After reviewing Resident # 80's dialysis communication book for the missing dates listed above, LPN # 2 stated that the communications sheets were not in the book. When asked about the incomplete communication form dated 07/03/21, LPN # 2 stated, "It should have been completed." When asked who was responsible for completing the dialysis communication forms, LPN # 2 stated, "The nurse taking care of the resident that day." On 07/28/2021 at approximately 5:00 p.m., ASM [administrative staff member] #1, director of clinical services, ASM # 2, director of nursing and ASM # 4, medical director, were made aware of the above concern. No further information was presented prior to exit. 5. The facility staff failed to evidence ongoing communication with the dialysis center for Resident #59. Resident #59 was admitted to the facility on 1/27/21 with diagnoses that included but were not limited to: diabetes mellitus (1), ESRD [end stage renal disease] (2), heart failure (inability of the heart to pump enough blood to maintain normal body requirements) (3) and cerebrovascular accident (4). The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 6/14/21, 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.	F 698		

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F 698	Continued From page 167 Section O: special treatments and procedures: was coded "Dialysis= yes." A review of the physician orders dated 6/10/21, documented in part, "ESRD Dialysis Days and Times: Tues [Tuesday], Thurs [Thursday], and Saturday pick up time 10:30 AM for 11:30 AM dialysis." A review was conducted of Resident #59's "Dialysis Communication Forms" located in his dialysis binder at the nursing station. A review of the forms in the binder from June 2021 and July 21 evidenced of the 21 dialysis treatments 6/10/21 through 7/27/21, there were three missing forms for the dates of 6/19/21, 6/26/21 and 7/17/21. An interview was conducted on 7/28/21 at 11:40 AM with LPN (licensed practical nurse) #2. When asked the purpose of the dialysis communication forms, LPN #2 stated, "They provide information to the dialysis facility regarding vital signs, any issues with the fistula or shunt, any signs or symptoms of infection. They send information back regarding any concerns during the dialysis treatment and weights." On 7/27/21 at 11:11 AM, when asked what standard of practice was followed in the facility, ASM (administrative staff member) #2, the director of nursing stated, "We follow our policies and procedures." On 7/28/21 at 5:30 PM, ASM #1, the regional director of clinical services, ASM #2, the director of nursing and ASM #4, the Medical Director were made aware of the concern.	F 698		

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F 698	Continued From page 168 The facility policy, "End-Stage Renal Disease, Care of a Resident with," documented in part, "Resident with end-stage renal disease (ESRD) will be care for according to currently recognized standards of care. 4. Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: How the care plan will be developed and implemented, how information will be exchanged between the facility." No further information was provided prior to exit. References: (1) Diabetes Mellitus -inability of insulin to function normally in the body. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (2) End Stage Renal Disease: inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 498. (3) Heart failure: inability of the heart to pump enough blood to maintain normal body requirements. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 259. (4) Cerebrovascular Accident (CVA): abnormal condition in which a hemorrhage or blockage of the blood vessels of the brain leads to a lack of oxygen. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. 6. The facility staff failed to evidence communication and coordination of dialysis care and services for Resident #52 between the facility	F 698		

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F 698	Continued From page 169 and the dialysis center. Resident #52 was most recently readmitted to the facility on 6/4/21 with the diagnoses of but not limited to sepsis, diabetes, stroke, dysphasia, dysphagia, insomnia, seizures, high blood pressure, end stage renal disease, pacemaker, and COVID-19. The most recent MDS (Minimum Data Set) was a quarterly / 5-day assessment with an ARD (Assessment Reference Date) of 6/9/21. The resident was coded as severely cognitively impaired in ability to make daily life decisions. A review of the clinical record revealed a physician's order dated 6/28/21 for "Hemodialysis Diagnosis: ESRD (End Stage Renal Disease). Dialysis days and time: Monday, Wednesday, Friday. Pick up time: 11:30am. Dialysis Center: (name, address, phone number, and transportation company contact was documented)." A review of the dialysis communication log revealed forms on which the facility was to document on the top half the following information as applicable, for the dialysis center review prior to performing dialysis: Vital signs, blood sugar, last pain medication given, wound sites, special precautions, additional comments. The second half of the form, the dialysis center was to document for the facility to review upon return from dialysis the following information: Pre dialysis weight and vital signs, post dialysis weight and vital signs, duration of treatment, medications administered, and new orders or comments.	F 698		

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F 698	Continued From page 170 A review of the dialysis log for July 2021 for Resident #52 revealed the following: July 2, 2021 - there was no communication log documentation from either facility to the other. July 7, 2021 - the dialysis center did not document on the communication log pertinent data for the facility. July 8, 2021 - the dialysis center did not document on the communication log pertinent data for the facility. July 16, 2021 - the dialysis center did not document on the communication log pertinent data for the facility. July 19, 2021 - there was no communication log documentation from either facility to the other. July 23, 2021 - the dialysis center did not document on the communication log pertinent data for the facility. July 28, 2021 - the facility did not document on the communication log pertinent data for the dialysis center. On 7/29/21 at 10:44 AM an interview was conducted with RN #4 (Registered Nurse). When asked about the purpose of the dialysis communication log, she stated it was to document and report to or from dialysis any change of condition, vital signs, weights, or alterations in relevant care and treatment. RN #4 stated that even if there were no changes in conditions or treatments, that at the very least, the vital signs should be documented by both facilities. On 7/29/21 at 10:48 AM an interview was conducted with LPN #7 (Licensed Practical Nurse). When asked about the purpose of the dialysis communication book, she stated that it	F 698		

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F 698	Continued From page 171 was for recording and communicating the resident's vital signs and weight to and from the dialysis center. When asked about logs that were left blank, and how either facility knew what the vitals and weights were for Resident #52, LPN # 7 stated, "They won't know." A review of the comprehensive care plan revealed one dated 11/30/20 for "Renal insufficiency related to chronic renal failure, presence of fistula/graft/catheter." This care plan included an intervention dated 11/30/20 for "Coordinate dialysis care with the dialysis treatment center." On 7/29/21 at 8:45 AM, the Regional Director of Clinical Services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. ASM #1 stated that it had already been identified that the completion of the dialysis communication log was a problem. No further information was provided by the end of the survey.	F 698		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.	F 732	**F732: Posted Nurse Staff Information** 1.Facility staffing schedule has been posted. 2.All residents have the potential to be affected by this alleged deficient practice. Regional Director of Clinical Services verified the staffing schedule was posted during the duration of survey.	

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F 732	Continued From page 172 (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post nurse staffing information. The facility staff failed to post nurse staffing information on 7/27/21 and on 7/28/21, during the morning. The findings include: On 7/27/21 at 11:05 a.m., 7/27/21 at 3:25 p.m. and 7/28/21 at 8:01 a.m., a tour of the facility and observations including the lobby failed to reveal	F 732	3.Administrator, or designee will educate Staffing Coordinator and if not present in facility, the backup staff member will post the staff schedule. The staffing schedule must be posted daily at the front desk. 4.Administrator or designee will verify the staffing assignment is posted at the front desk weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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F 732	Continued From page 173 posting of the nurse staffing information. On 7/28/21 at 9:11 a.m., an interview was conducted with OSM (other staff member) #5 (the staffing coordinator). OSM #5 stated each day when she comes to the facility, she is supposed to look at the schedule for the day, document information on the nurse staffing form and post the form in the front lobby. OSM #5 stated she did not arrive to the facility until 1:00 p.m. on 7/27/21 and did not post nurse staffing information that day. OSM #5 stated she arrived late to the facility on this date (7/28/21) and had completed the form but had not posted the form. OSM #5 stated there was not a backup person to complete this task when she is not in the facility. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Posting Direct Care Daily Staffing Numbers" documented, "Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents." No further information was presented prior to exit.	F 732		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755	**F755: Pharmacy Services/Procedures/Pharmacist Records** 1.Expired Medication has been removed from medication rooms and disposed of appropriately.	

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GLENBURNIE REHAB & NURSING CENTER	1901 LIBBIE AVE RICHMOND, VA 23226

(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 755	Continued From page 174 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to ensure expired medication was disposed of and not available for use in one of two medication rooms, (the Bradford unit medication room). Multiple expired IV (intravenous) medications were observed in the Bradford unit medication room refrigerator available for resident administration.	F 755	2.All residents have the potential to be affected by this alleged deficient practice. Nursing management will audit the expiration dates on medications in the medication room and the medication carts and will discard any identified expired. 3.DON or designee will educate all nursing staff on medications being discarded appropriately from Med Cart and/or Med room when expired. 4.DON or designee will audit Med Carts and Med rooms weekly times 4 weeks and monthly times 2 to ensure medication is not expired. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will August 20, 2021.	

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F 755	Continued From page 175 The findings include: Observation was made of the Bradford unit medication room on 7/29/2021 at 9:23 a.m. The following medications were located in the refrigerator in the medication room available for use: *2000 ml (milliliters) bag of TPN (total parental nutrition) solution - expired on 7/22/2021 -the resident on the label had been discharged. *Six bags of 100 cc (cubic centimeter) of dextrose with Penicillin G (used to treat infections caused by bacteria) (1) 4 mg (milligrams) per 50 ml - expired on 7/24/2021. - Resident on the label was still in the facility. *Two bags of 100 cc of 0.9% Normal Saline with Meropenem (used to treat skin and abdominal (stomach area) infections caused by bacteria and meningitis (infection of the membranes that surround the brain and spinal cord.) (2) 2 gm (grams)/100 ml - expired on 7/23/2021. Resident on the label was still in the facility. *Two bags of 100 cc of dextrose with Penicillin G - expired on 7/26/2021 - resident was still in the facility. *Three bags of 100 cc of dextrose with Cefazolin (used to treat certain infections caused by bacteria including skin, bone, joint, genital, blood, heart valve, respiratory tract [including pneumonia], biliary tract, and urinary tract infections.) (3) - expired on 7/26/2021 - resident on the label was still in the facility. *Four bags of 0.9% Normal Saline with Meropenem 2 gm/100 ml - expired on 7/25/2021. The resident on the label was still in the facility. On 7/29/2021 at 9:35 a.m., an interview was conducted with LPN (licensed practical nurse) #3, LPN #6, LPN #2 and LPN #9. When asked why	F 755		

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F 755	Continued From page 176 there are so many expired IV (intravenous) medications in the refrigerator, LPN #3 stated the pharmacy sends them and the staff throw them in the refrigerator. LPN #3 stated the pharmacy normally sends extras of them. When asked about the process staff follows for administration an IV medication, LPN #2 stated they do the six rights of medication administration and check for the expiration date. When asked about the process followed for returning medications to the pharmacy, LPN #3 stated the pharmacy only allows pick up of returned medications on Mondays and Thursday. The pharmacy also limits the amount of boxed up medication that can be returned at one time, the limit is two boxes and if the box is too heavy; the pharmacy staff member will not take it. LPN #2 stated she had offered to drop the boxes of medication off to the pharmacy and was told they were not allowed to do that. LPN #9 stated this unit is the skilled unit and they have many discharges each day and there are so many medications that need to be returned to the pharmacy. The facility policy, "Storage of Medications" documented in part, "4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed...7. ASM (administrative staff member) #1, the regional director of clinical services and ASM #2, the director of nursing, were made aware of the above findings on 7/29/2021 at 10:41 a.m. No further information was provided prior to exit. References: (1) This information was obtained from the	F 755		

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F 755	Continued From page 177 following website: https://medlineplus.gov/druginfo/meds/a685013.html (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a696038.html (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682731.html	F 755		
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:	F 757	**F757: Drug Regimen is Free from Unnecessary Drugs** 1.Resident #27 continues to reside in the facility with the pain medication administration only after non-pharmacological interventions have been utilized and administered appropriately following MD order. Resident #114 has been discharged from the facility. 2.All residents have the potential to be affected by this alleged deficient practice. Nursing management will audit for non-pharmacological interventions implemented prior to administering prn pain medication. 3.DON or designee will educate all nursing staff on implementing non-pharmacological interventions prior to administering prn pain medications.	

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F 757	Continued From page 178 Based on staff interview, clinical record review and review of facility documentation the facility staff failed to ensure the medication regimen for two of 49 sampled residents (Resident #114, and Resident #27) was free of unnecessary medications. 1. The facility staff administered the narcotic pain medication Hydrocodone-Acetaminophen to Resident #114, for pain scale ratings below the physician ordered parameters of severe pain (8-10) and failed to attempt non-pharmacological interventions prior to administering the medication. 2. Resident #27 received Diclofenac Sodium Gel 1% (topical analgesic) medication ordered for moderate pain, when pain level was zero. The findings include: 1. Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat) (3).	F 757	4.DON or designee will audit prn pain medication administration to ensure non-pharmacological interventions have been implemented prior to administering the prn pain medication weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will August 20, 2021.	

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F 757	Continued From page 179 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, coded Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as limited assistance of one staff member for most of her activities of daily living. In Section J - Health Conditions the resident was coded as having no pain in the past 5 days. The physician orders dated 6/23/2021 documented, "Hydrocodone-Acetaminophen Tablet (used to treat severe pain) (3) 5-325 MG (milligrams) Give 1 tablet by mouth every 6 hours as needed for severe pain." The order dated, 6/1/2021, documented, "Pain Score every shift: 0 = no pain, 1,2,3,4 - mild pain, 5, 6, 7 = moderate pain, 8,9,10 = severe pain. every shift for pain." The July 2021 MAR (medication administration record) for Resident #114 documented the physician order above for Hydrocodone - Acetaminophen. The MAR documented the medication was administered on the following dates, and times with pain scale ratings below the physician ordered parameters for severe pain as follows: 7/13/2021 at 9:55 p.m. - pain level - 6 7/15/2021 at 9:53 a.m. - pain level - 6 7/15/2021 at 7:29 p.m. - pain level - 7 7/16/2021 at 10:10 a.m. - pain level - 6 7/16/2021 at 9:03 p.m. - pain level - 7 7/17/2021 at 10:50 a.m. - pain level - 7 7/18/2021 at 5:54 a.m. - pain level - 7 7/18/2021 at 9:09 p.m. - pain level - 7 7/20/2021 at 10:15 p.m. - pain level - 0 7/21/2021 at 11:34 a.m. - pain level - 4	F 757		

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F 757	Continued From page 180 7/22/2021 at 1:26 a.m. - pain level - 6 7/23/2021 at 12:57 a.m. - pain level - 2 7/23/2021 at 9:30 a.m. - pain level - 5 7/24/2021 at 1:10 a.m. - pain level - 0 7/26/2021 at 9:25 a.m. - pain level - 7 Review of the nurses' notes for Resident #114 revealed the following documentation: 7/13/2021 at 9:55 p.m. - did not document the location of the pain or any non-pharmacological interventions attempted/provided prior to the administration of the Hydrocodone-Acetaminophen. 7/15/2021 at 9:53 a.m. - There was no nurse's note or eMAR (electronic medication administration record) note and no pain assessment or non-pharmacological interventions attempted/provided documented. 7/15/2021 at 7:29 p.m., 7/16/2021 at 10:10 a.m., 7/16/2021 at 9:03 p.m., 7/17/2021 at 10:50 a.m., each date and time, failed to reveal any documented location of the pain or any non-pharmacological interventions attempted/provided prior to the administration of the Hydrocodone-Acetaminophen. 7/18/2021 at 5:54 a.m. - There was no nurse's note or eMAR note. No pain assessment or interventions attempted/provided prior to the administration of the Hydrocodone-Acetaminophen. 7/18/2021 at 9:09 p.m. and 7/20/2021 at 10:15 p.m. - there was no documented location of the pain or any non-pharmacological interventions attempted/provided prior to the administration of the Hydrocodone-Acetaminophen. 7/21/2021 at 11:34 a.m. 7/22/2021 at 1:26 a.m., 7/23/2021 at 12:57 a.m., 7/23/2021 at 9:30 a.m., 7/24/2021 at 1:10 a.m. and 7/26/2021 at 9:25 a.m., for each date and time there was no nurse's	F 757		

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F 757	Continued From page 181 note or eMAR note. No pain assessment or non-pharmacological interventions attempted/provided documented prior to the administration of the Hydrocodone-Acetaminophen. The comprehensive care plan dated 6/25/2021 documented in part, "Focus: Pain related to dependence on renal dialysis, muscle weakness, fluid overload, disease process." the "Interventions/Tasks" documented in part, "Administer pain medication per physician orders. Notify physician if pain frequency/intensity is worsening or of current analgesia regimen has become ineffective." An interview was conducted with LPN (licensed practical nurse) #6 on 7/28/2021 at 12:19 p.m. LPN #6 was asked to review the above physician's order for Hydrocodone - Acetaminophen. When asked if the medication should be given for a pain level between one and seven, LPN #2 stated the resident usually requests which medication she wants. When asked according to the order and the facility documentation of the pain scale, should this medication be given for a pain level of seven and below, LPN #2 stated, "No, I guess not." An interview was conducted with LPN #3, the unit manager; on 7/28/2021 at 2:36 p.m., LPN #3 was asked to review the above physician's order for Hydrocodone - Acetaminophen. LPN #3 was asked when a nurse should give this medication if the order documents for severe pain. LPN #3 stated, "When she has a pain level of eight, nine or ten." The facility policy, "Administering Pain	F 757		

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F 757	Continued From page 182 Medications" documented in part, "Purpose: The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication...3. Conduct a pain assessment as indicated...5. Evaluate and document the effectiveness of non-pharmacological interventions (e.g.; repositioning, warm or cold compresses, etc.). 6. Administer pain medications as ordered." ASM (administrative staff member) #1, the regional director of clinical services and ASM #2, the director of nursing, were made aware of the above concern on 7/28/2021 at 5:07 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 266. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 43. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a614045.html 2. Resident #27 was admitted to the facility on 5/11/21 with diagnosis that included but were not limited to: diabetes mellitus (inability of insulin to function normally in the body) (3), right below the knee amputation [BKA] (surgical removal of a	F 757		

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F 757	Continued From page 183 limb) (4) and PTSD [post-traumatic stress disorder] (mood disorder occurring after a traumatic event) (5). The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an ARD (assessment reference date) of 5/17/21, coded the resident as scoring a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer, locomotion and dressing. Independence in eating and supervision for hygiene/bathing. Walking did not occur. A review of MDS Section H- Bowel and Bladder coded the resident as frequently incontinent for bowel and for bladder. A review of the care plan dated 5/20/21, documented in part, "FOCUS: Pain related to right BKA, disease Process. INTERVENTIONS: Administered pain medication per physician orders. Notify physician if pain frequency/intensity is worsening or of current analgesia regimen has become ineffective." A review of the physician orders dated 7/14/21, documented in part, "Diclofenac Sodium Gel 1%, apply to lower back topically every 6 hours for moderate back pain, apply 4 grams." A review of the physician orders dated 7/19/21, documented in part, "Pain Score every shift: 0=No pain, 1, 2, 3, 4=Mild pain, 5, 6, 7=Moderate pain, 8, 9, 10=Severe Pain, every shift for pain." A review of the MAR (medication administration record), documented in part, "Diclofenac Sodium Gel 1% administered on 7/19/21 at 12:00 PM	F 757		

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F 757	Continued From page 184	F 757		

pain level=0, 7/20/21 at 6:00 AM pain level=0, 7/20/21 at 6:00 PM pain level=0. On 7/21/21 12:00 AM pain level=0, 6:00 AM pain level=0, 12:00 PM pain level=0, 6:00 PM pain level=0. On 7/22/21 6:00 AM pain level=0, and 12:00 PM pain level=0."

An interview was conducted on 7/28/21 at 3:05 PM with LPN (licensed practical nurse) #2. When asked what does the zero on the pain scale means, LPN #2 stated, "It means no pain, and the way I think about it, is that the pain medication is working." When asked to review Resident #27's MAR , LPN #2 stated, "The pain scale is documented as 0 and the order is for Diclofenac Sodium Gel 1% apply to lower back topically every 6 hours for moderate back pain, apply 4 grams." When asked if zero is moderate pain, LPN #2 stated, "No, but I take it to mean to give the gel so he won't have pain. I think you can look at it that way. I see how looking at it from the physician's order and that way should not give it."

An interview was conducted on 7/28/21 at 3:15 PM with LPN #6. When asked if a resident who has orders for pain medication for moderate pain should they receive the pain medication if the pain rating level is zero, LPN #6 stated, "According to the parameters, he shouldn't get the gel if pain level is zero."

(6) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 319.
(7) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 282.
(8) Barron's Dictionary of Medical Terms for the

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F 757	Continued From page 185 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758	**F758: Free from Unnecessary Psychotropic Meds/PRN Use** 1.Resident #62 still resides in facility and is being monitored for behaviors and side effects for the use of Psychotropic Medications. Resident #114 has been discharged from the facility. 2.All residents have the potential to be affected by this alleged deficient practice. Nursing management will audit the behavior and side effect monitoring in PCC for documentation. Audit the prn psychotropic medication for stop date, documentation of non-pharmacological interventions implemented prior to administering the prn psychotropic medication. 3.DON or designee will educate all nursing staff on Residents receiving prn Psychotropic Medications must have stop date. Must have documentation in PCC for monitoring of behaviors and side effects and use of nonpharmacological interventions prior to administering a prn psychotropic medication with documentation.	

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	495391	A. BUILDING _____ B. WING _____	C 07/29/2021

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F 758	Continued From page 186 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure residents were free of unnecessary psychotropic medications for two of 49 residents in the survey sample, Residents #62 and #114. 1. The facility staff failed to monitor Resident #62 for targeted behaviors and side effects for the use of Seroquel (1). 2. The facility staff failed to offer non-pharmacological interventions prior to the administration of the as needed (PRN) Ativan an anti-anxiety medication, failed to document the reason for the administration of Ativan anti-anxiety medication, failed to have a stop date for the as needed Ativan anti-anxiety medication and the physician/nurse practitioner failed to document the monitoring for the use of an anti-anxiety medication for Resident #114. The findings include:	F 758	4.DON or designee will audit Residents that admit or have new orders for prn psychotropic medications have stop date, behavior and side effect monitoring and non-pharmacological interventions utilized prior to administering a prn psychotropic medication weekly times 4 weeks and monthly times 2. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. Date of compliance will August 20, 2021.	

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F 758	Continued From page 187 1. Resident #62 was admitted to the facility on 1/20/17. Resident #62's diagnoses included but were not limited to obsessive compulsive disorder, major depressive disorder and low back pain. Resident #62's significant change in status minimum data set assessment with an assessment reference date of 3/15/21, coded the resident as being cognitively intact. Section N coded Resident #62 as having received antipsychotic medication six out of the last seven days. Review of Resident #62's clinical record revealed a physician's order dated 3/10/21 for Seroquel 25 mg (milligrams) by mouth at bedtime for psychosis. Review of Resident #62's MARs (medication administration records) from 3/10/21 through 7/26/21 revealed the documentation evidencing resident received Seroquel 25 mg each night. Resident #62's comprehensive care plan revised on 2/2/17 failed to document information regarding antipsychotic medication use. Further review of Resident #62's clinical record, including MARs and nurses' notes from 3/10/21 through 7/26/21 failed to reveal evidence that the resident was monitored for targeted behaviors or side effects for the use of Seroquel. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated Resident #62 receives Seroquel for behaviors related to obsessive compulsive disorder. LPN #4 stated residents who receive antipsychotic medication should be monitored for behaviors and side effects, and this is	F 758		

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F 758	Continued From page 188 documented on the MAR. LPN #4 reviewed Resident #62's July 2021 MAR and stated behavior and side effect monitoring should be documented but was not. LPN #4 stated she would fix this. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1, the regional director of clinical services and ASM #2, the director of nursing were made aware of the above concern. The facility policy titled, "Antipsychotic Medication Use" documented, "16. The staff will observe, document and report to the Attending Physician information regarding the effectiveness of any interventions, including antipsychotic medications. 17. Nursing staff shall monitor for and report any of the following side effects..." No further information was presented prior to exit. Reference: (1) "Quetiapine (Seroquel) tablets and extended-release (long-acting) tablets are used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions). Quetiapine tablets and extended-release tablets are also used alone or with other medications to treat episodes of mania (frenzied, abnormally excited or irritated mood) or depression in patients with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods). In addition, quetiapine tablets and extended-release tablets are used with other medications to prevent episodes of mania or depression in patients with bipolar disorder. Quetiapine extended-release	F 758		

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F 758	Continued From page 189 tablets are also used along with other medications to treat depression." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a698019.html 2. Resident # 114 was admitted to the facility on 5/27/2021 with a recent readmission on 7/9/2021, with diagnoses that included but were not limited to: end stage renal disease requiring hemodialysis (a procedure used in toxic conditions and renal [kidney] failure, in which wastes and impurities are removed from the blood by a special machine) (1), chronic obstructive pulmonary disease (COPD - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2) high blood pressure and anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/15/2021, Resident # 114 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as limited assistance of one staff member for most of her activities of daily living. In Section N - Medications, the resident was coded as receiving two days of an antianxiety medication during the look back period. The physician order dated 6/14/2021, documented, "Ativan tablet (used to treat anxiety)	F 758		

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F 758	Continued From page 190 (4) 0.5 mg (milligrams) (Lorazepam) Give .25 mg by mouth every 8 hours as needed for anxiety." Review of Resident #114's June 2021 MAR (medication administration record) documented the above physician order for as needed Ativan. Further review of the MAR revealed documentation the Ativan was administered on the following dates and times: 6/16/2021 at 11:16 a.m., 6/16/2021 at 8:09 p.m., 6/19/2021 at 10:22 p.m., 6/23/2021 at 12:48 p.m., 6/25/2021 at 3:37 a.m., 6/25/2021 at 10:51 a.m., 6/27/2021 at 10:48 a.m. and 6/30/2021 at 11:40 a.m. Review of Resident #114's nurses' notes for June 2021, revealed there was no documented evidence of why the medication (targeted behavior) was given or what non-pharmacological interventions were attempted/ provided prior to the administration of the Ativan on the following dates and times: 6/16/2021 at 11:16 a.m., 6/16/2021 at 8:09 p.m., 6/19/2021 at 10:22 a.m., 6/23/2021 at 12:48 p.m., 6/25/2021 at 3:37 a.m., 6/27/2021 at 10:48 a.m., and on 6/30/2021 at 11:40 a.m. The July 2021 MAR documented the above physician order for as needed Ativan. Further review of the MAR revealed documentation the Ativan was administered on the following dates and times: 7/1/2021 at 2:01 p.m., 7/2/2021 at 10:46 p.m., 7/4/2021 at 12:06 a.m., 7/10/2021 at 4:14 a.m., 7/11/2021 at 6:57 p.m., 7/15/2021 at 7:29 p.m., 7/16/2021 at 10:10 a.m., 7/18/2021 at 11:16 a.m., 7/18/2021 at 10:48 p.m., 7/20/2021 at 11:02 a.m., 7/21/2021 at 7:08 a.m., 7/21/2021 at 6:42 p.m.,	F 758		

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F 758	Continued From page 191 7/22/2021 at 11:56 a.m., and on 7/23/2021 at 7:08 a.m. Review of Resident #114's nurses' notes for July 2021, revealed there was no documented evidence of why the medication (targeted behavior) was given or what non-pharmacological interventions were attempted/ provided prior to the administration of the Ativan on the following dates and times: 7/1/2021 at 2:01 p.m., 7/2/2021 at 10:46 p.m., 7/4/2021 at 12:06 a.m., 7/10/2021 at 4:14 a.m., 7/11/2021 at 6:57 p.m., 7/15/2021 at 7:29 p.m., 7/16/2021 at 10:10 a.m., 7/18/2021 at 11:16 a.m. 7/18/2021 at 10:48 p.m., 7/20/2021 at 11:02 a.m., 7/21/2021 at 7:08 a.m.,7/21/2021 at 6:42 p.m.,7/22/2021 at 11:56 a.m., and on 7/23/2021 at 7:08 a.m. The comprehensive care plan dated, 6/25/2021, documented in part, "Focus: At risk for adverse effects related to use of anti-depression medication." The review of the care plan failed to evidence a care plan related to the use of an anti-anxiety medication. The nurse practitioner note, dated, 6/15/2021, documented in part, "Plan: Anxiety and insomnia - reordered the lorazepam 0.25 mg q (every) 8 h (hours) PRN (as needed) anxiety. Spoke with pharmacy to confirm." The nurse practitioner note dated, 6/17/2021, documented in part, "Plan: Anxiety and insomnia - seems to be improved this morning, but she is a little drowsy. The lorazepam does seem to be helping, will need to monitor for over-sedation. For now, continue half a tablet (0.25 mg) every 8 hours as needed."	F 758		

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F 758	Continued From page 192 The nurse practitioner note, dated 6/24/2021, documented in part, "Plan: Anxiety and insomnia - continue lorazepam 0.25 mg q8h PRN anxiety." The nurse practitioner note, dated 7/12/2021, documented in part, "Plan: Anxiety and insomnia - continue lorazepam 0.25 mg q8h PRN anxiety." An interview was conducted with LPN (licensed practical nurse) #3, the unit manager, on 7/28/2021 at 3:16 p.m. The above order for Ativan was reviewed with LPN #3. When asked when or why a nurse would administer the medication to Resident #114, LPN #3 stated, "If the resident is anxious. First, you assess the resident. Find out why they are anxious, what is causing the anxiousness? Offer to see if anything else would help them relax, calm them down, like non-pharmacologicals." When asked where this information would be documented, LPN #3 stated, "It should be documented in the nurses' note or eMAR (electronic medication administration record)." An interview was conducted with LPN #6, on 7/28/2021 at 3:23 p.m. The above order was reviewed with LPN #6. When asked when or why a nurse would administer the medication to Resident #114, LPN #6 stated, "I'd give it for increased anxiety." When asked about the process staff follows for administering the Ativan, LPN #6 stated, "First you do an assessment. You try to redirect them with conversation, offering a snack. But this resident will request the Ativan." When asked where the assessment and any attempted non-pharmacological interventions are documented, LPN #6 stated, "It's supposed to be in the eMAR note. If it's not there it wasn't done."	F 758		

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F 758	Continued From page 193 An interview was conducted with ASM (administrative staff member) #3, the nurse practitioner, on 7/29/2021 at 10:01 a.m. When asked the about process for administering anti-anxiety medications, ASM #3 stated, "I know we are not supposed to have them. I came from a primary care setting and we prescribed PRN (as needed) anti-anxiety medications for elderly patients." When asked why Resident #114 was receiving the Ativan, ASM #3 stated, "She was having shortness of breath, high blood pressure, insomnia, headaches, and was calling 911 for her shortness of breath. I had a conversation with her, she reported she was having trouble with her nerves. We did a trial of the anti-anxiety medication. The use of it has helped her stay out of the hospital since we ordered it. I hate the fact that we can't order a PRN. I do think there are people that have panic disorder that doesn't need it scheduled. For her (Resident #114) it's more episodic anxiety causing shortness of breath and going to the ER (emergency room)." When asked how long a PRN anti-anxiety medication can be ordered for, ASM #3 stated she depends on the nurses to help with that stuff for stop dates such as antibiotics and deep vein thrombosis prophylaxis." When asked if she was aware of a limitation of 14 days for the use of a PRN anti-anxiety medication, ASM #3 stated she was not. When asked if she had documented everything that she stated above as to why Resident #114 was prescribed and administered the Ativan as needed, ASM #3 stated, she had not documented those details. The facility policy, "Medication Therapy" documented in part," Policy Statement: 1. Each resident' medication regimen shall include only those medications necessary to treat existing	F 758		

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F 758	Continued From page 194 conditions and address significant risks. 2. Medication use shall be consistent with an individual's condition, prognosis, values, wishes and responses to such treatments. 3. All medication orders will be supported by appropriate care processes and practices...Policy interpretation and implementation: 2. All decisions related to medications shall include appropriate elements of the care process, such as: adequately detailed assessment, review of causes of symptoms, consideration for the clinical relevance of symptoms and abnormal diagnostic test results, principles of prescribing for the elderly and each resident's wishes, values, goals, condition and prognosis. 4. Periodically and when circumstances are present that represent a greater risk for medication-related complications, the staff and practitioner will review the medication regimen for continued indications, proper dosage and duration and possible adverse consequences. 5. The Physician will identify situations where medications should be tapered, discontinued, or changed to another medication, for example, when a resident is being given in excessive doses, for excessive periods of time, without adequate monitoring, or in the absence of a valid clinical rationale." ASM #1, the regional director of clinical services, was made aware of the above findings on 7/29/2021 at 11:38 a.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 266. (2) Barron's Dictionary of Medical Terms for the	F 758		

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F 758	Continued From page 195 Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 43. (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682053.html	F 758	**F804: Nutritive Value/Appear, Palatable/Prefer Temp** 1.Any Resident voicing concerns related to food temperature or palatability are offered alternative meal. 2.All residents have the potential to be affected by this alleged deficient practice. Dietary Manager will audit food temperatures on current meal served. 3.Administrator or designee will educate Dietary staff on maintaining temperatures for foods and ensuring food is palatable. 4.Dietray Manager or designee will audit meals for presentation, palatability, and appropriate food temperatures weekly times 4 weeks then monthly x 2 months. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will August 24, 2021.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and facility document review, it was determined that the facility staff failed to serve food at temperatures and flavor that was palatable for meal enjoyment. The findings include: During the survey process for individual resident interviews, surveyors reported that multiple residents with a BIMS of 15 (Brief Interview for Mental Status - which scores cognitive status from 0 to 15 with 0 being severely cognitively impaired and 15 being cognitively intact)	F 804		

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F 804	Continued From page 196 complained of the food being cold and "not good." On 7/28/21 at 11:40 AM, observation of the trayline was conducted. The temperatures were obtained with a facility thermometer by a dietary staff member. OSM #14 (Other Staff Member) the dietary manager, and OSM #16, a consultant for dietary services, were present. The temperatures were as follows: Riblet: Regular 170 degrees; Pureed 153 degrees. Corn: Regular 190 degrees. Cabbage: Regular 190 degrees; Pureed 161 degrees. Coleslaw: Regular 37.6 degrees. Mashed potatoes: 175 degrees. On 7/28/21 at 12:31 PM a test tray was prepared and placed on the meal cart to the unit. Once all residents were served, at 12:51PM the test tray was evaluated. The food temperatures were obtained with a facility thermometer by OSM #16 and were as follows: Riblet: Regular 98 degrees, a 72 degree drop in temperature; Pureed 120 degrees, a 33 degree drop in temperature. Corn: Regular 120 degrees, a 70 degree drop in temperature. Cabbage: Regular 119 degrees, a 71 degree drop in temperature; Pureed 129 degrees, a 32 degree drop in temperature. Coleslaw: Regular 51 degrees, a 13.4 degree increase in temperature. Mashed potatoes: 135 degrees, a 40 degree drop in temperature. Two surveyors and OSM #16 taste tested all the	F 804		

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F 804	Continued From page 197 food items. It was agreed that the regular textured cabbage and riblet were not warm enough for meal enjoyment. It was also agreed that the mashed potatoes were bland and had an undesirable off-taste and texture about them that was different than normal bland potatoes that had not been seasoned. It was noted that earlier during meal preparation (approximately 11:30 AM) the potatoes were observed being prepared and were not made with real potatoes, but was a boxed powder or flake type potato product. In addition, a piece of carrot cake, which was dessert, that was at room temperature (was not a hot or cold food item) was tasted and noted to be on the dry side, and had a thin layer of a yellow colored pudding-like product "icing" instead of the traditional cream cheese frosting. On 7/28/21 at 1:45 PM, OSM #14, OSM #16, and OSM #15 (Senior Director of Culinary Services), were notified of the above test tray concerns. OSM #16 agreed the food items were cold and/or not flavorful. OSM #15 stated that they should be and they will be doing education and troubleshooting on causes. OSM #14 stated she will look at evaluating other brands of mashed potato products for a better option. A review of the facility policy, "Food and Nutrition Services Staff" documented, "... 4. Food will be palatable, attractive, and served in a timely manner at proper temperatures....." On 7/29/21 at 8:45 AM, the Regional Director of Clinical Services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey.	F 804		

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F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store food in a sanitary manner. In the freezer an unsealed box of fish fillets was observed fish fillets in the box were exposed to the environment in the freezer and a bottle of opened thickened orange juice, half used, was not dated with an opened date or placed in the refrigerator after opening. The findings include: On 7/27/21 at 11:37 AM an inspection and observation of the kitchen was conducted. In the	F 812	**F812: Food Procurement, Store/Prepare/Serve-Sanitary** 1.The box of fish fillets and thickened orange juice were discarded on 7/27/2021. 2.All residents have the potential to be affected by this alleged deficient practice. Audit was conducted for open food items to verify dated and stored appropriately. 3.Dietry Manager or designee will educate Dietary staff on food storage and date open food items. 4.Dieatry Manager or designee will audit food storage and open food items dated weekly times 4 weeks then monthly x 2 months. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will August 20, 2021.	

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F 812	Continued From page 199	F 812		

freezer an unsealed box of frozen fish fillets was observed. The fish fillets in the box were exposed to the environment in the freezer. In the pantry, a bottle of thickened orange juice had been opened, half used, and was not dated with an opened date or placed in the refrigerator after opening.

On 7/27/21 at approximately 11:45 AM, OSM #14 (Other Staff Member) the dietary manager stated that the fillets should have been sealed and the orange juice should have been dated and refrigerated.

On 7/28/21 at the end of the day at approximately 5:00 PM, the facility was provided with a list of policy requests by the survey team. One for proper storing/preparing/serving of food was requested. A review of the facility policies provided as related to dietary services failed to reveal any criteria for the proper storage of food.

3-305.11 Food Storage.
(A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD:
(1) In a clean, dry location;
(2) Where it is not exposed to splash, dust, or other contamination; and
(3) At least 15 cm (6 inches) above the floor.

3-202.15 Package Integrity.
Damaged or incorrectly applied packaging may allow the entry of bacteria or other contaminants into the contained food. If the integrity of the packaging has been compromised, contaminants such as Clostridium botulinum may find their way into the food. In anaerobic conditions (lack of oxygen), botulism toxin may be formed.

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F 812	Continued From page 200 According to the Federal Food and Drug Administration Food Code, 2017: 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first-prepared ingredient. (D) A date marking system that meets the criteria stated in (A) and (B) of this section may include: (1) Using a method APPROVED by the REGULATORY AUTHORITY for refrigerated, READY-TO-EAT TIME/TEMPERATURE	F 812		

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F 812	Continued From page 201 CONTROL FOR SAFETY FOOD that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine; (2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. On 7/29/21 at 8:45 AM, the Regional Director of Clinical Services, Director of Nursing and Medical Director (Administrative Staff Members (ASM) #1, #2, and #3 respectively) were made aware of the findings. No further information was provided by the end of the survey.	F 812		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to maintain the dumpster area	F 814	**F814: Dispose Garbage and Refuse Property** 1.The dumpster area was immediately cleaned at time of finding. 2.All residents have the potential to be affected by this alleged deficient practice. Audit conducted next day to verify no debri on ground around dumpster.	

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F 814	Continued From page 202 in a sanitary manner. The findings include: On 7/29/21 at 9:00 AM an inspection of the dumpster area was conducted. The following items were noted: A large card board box flattened and partially under a dumpster. A broken glass bottle. A bottle cap. A plastic 6-hole ring from a 6-pack of canned or bottle beverages. Multiple pieces of assorted plastic packaging for various food and medical supplies. A pile of string or yarn like material in red, white and blue colors. Significant amount of ants trailing to and from the dumpster. On 7/29/21 at 9:30 AM, an interview was conducted with OSM #14 (Other Staff Member) the dietary manager and OSM #15, the Senior Director of Culinary Services. They were shown the dumpster area at this time. They agreed the items should not be on the ground. They stated that multiple departments use the dumpster area but that ultimately, the dietary department is responsible for the dumpster area. A review of the facility policy, "Food-Related Garbage and Refuse Disposal" documented, "7. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter." On 7/29/21 at 8:45 AM, the ASM #1, the Regional	F 814	3.Administrator or designee will educate staff on keeping the dumpster area clean, sanitary and the top of dumpster must remain closed to prevent rodents and pest. 4.Administrator or designee will audit the dumpster area to verify no debri on grounds weekly times 4 weeks then monthly x 2 months. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will August 20, 2021.	

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F 814	Continued From page 203 Director of Clinical Services (Administrative Staff Member) was made aware of the findings. No further information was provided by the end of the survey.	F 814	**F842: Resident Records – Identifiable Information**	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (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,	F 842	1.Resident #101 continues to reside in facility and all duplicate orders have been discontinued and all orders are via PEG tube. Resident #59 has been discharged from the facility. 2.All residents have the potential to be affected by this alleged deficient practice. Nursing management will audit current residents with a peg tube and a physician order for NPO to verify medications are ordered via peg tube. An audit of current residents with dialysis sites to verify documentation for assessing dialysis site. 3.DON or designee will educate all nurses on the process for physician orders for peg tube with a NPO status have medications ordered via peg tube. 4.DON or designee will audit residents with peg tube and a NPO order to verify the medications have been ordered via peg tube and audit resident with dialysis sites having documentation assessing dialysis site weekly and audit times 4 weeks and monthly times Any	

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F 842	Continued From page 204 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to maintain a complete and accurate medical record for two of 49 residents in the survey sample, Resident #59 and Resident	F 842	identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5.Date of compliance will be August 20, 2021.	

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F 842	Continued From page 205 #101. The findings include: 1. The facility staff failed to document the assessment of Resident #59's the AV [arteriovenous] shunt for bruit and thrill every shift, on seven shifts in June 2021 and on eleven shifts in July 2021. Resident #59 was admitted to the facility on 1/27/21 with diagnosis that included but were not limited to: diabetes mellitus (inability of insulin to function normally in the body) (1), ESRD [end stage renal disease] (inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance) (2), heart failure (inability of the heart to pump enough blood to maintain normal body requirements) (3) and cerebrovascular accident (abnormal condition in which a hemorrhage or blockage of the blood vessels of the brain leads to a lack of oxygen) (4). The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 6/14/21, 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. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for locomotion, limited assistance with dressing and bathing; supervision was required for hygiene, transfer, and bed mobility, walking, eating and dressing. A review of MDS Section H-Bowel and Bladder coded the resident as always continent for bowel and occasionally incontinent for bladder.	F 842		

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F 842	Continued From page 206 A review of the physician orders dated 6/10/21, documented in part, "Dialysis: site of arterial vascular shunt-check bruit and thrill every shift." A review of the TAR (treatment administration record) failed to show documentation for the bruit and thrill on seven of the sixty shifts in June 2021 and eleven of the seventy nine shifts in July 2021. An interview was conducted on 7/28/21 at 3:05 PM with LPN (licensed practical nurse) #2. When asked the blank spaces on the TAR (treatment administration record) mean, LPN #2 stated, "Legally it means it was not done, but it could mean it was not documented." On 7/27/21 at 11:11 AM, when asked what standard of practice was followed in the facility, ASM (administrative staff member) #2, the director of nursing stated, "We follow our policies and procedures." According to the facility's "Charting and Documentation" revised July 2017, which documents in part, "The following information is to be documented in the resident medical record: treatments or services performed. Documentation of procedures and treatments will include care-specific details." On 7/28/21 at 5:30 PM, ASM #1, the regional director of clinical services, ASM #2, the director of nursing and ASM #4, the Medical Director were made aware of the concern. No further information was provided prior to exit. References:	F 842		

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F 842	Continued From page 207 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 160. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 498. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 259. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. 2.a. The facility staff failed to ensure an inaccurate physician's order for loratadine (1) was not entered into Resident #101's clinical record and failed to ensure accurate documentation for administration of the medication. Resident #101 was admitted to the facility on 5/18/07. Resident #101's diagnoses included but were not limited to multiple sclerosis (2), seizures and high blood pressure. Resident #101's quarterly minimum data set assessment with an assessment reference date of 7/6/21, coded the resident's cognitive skills for daily decision making as severely impaired. Review of Resident #101's clinical record revealed a physician's order dated 6/17/21 for nothing by mouth. Further review of Resident #101's clinical record revealed a physician's order dated 6/17/21 for loratadine 10 mg (milligrams) via PEG [percutaneous endoscopic gastrostomy tube] tube (a feeding tube inserted into the stomach) one time a day for chronic obstructive pulmonary disease (lung disease) and a physician's order dated 7/25/21 for loratadine 10 mg by mouth one	F 842		

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F 842	Continued From page 208 time a day for a rash. Review of Resident #101's July 2021 MAR (medication administration record) revealed documentation that 10 mg of loratadine was administered to the resident via PEG tube from 7/26/21 through 7/28/21 and 10 mg of loratadine was administered to the resident by mouth from 7/26/21 through 7/28/21. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse who signed off administration of both loratadine orders from 7/26/21 through 7/28/21. LPN #4 stated Resident #101 could not receive medications by mouth and received medications via PEG tube. LPN #4 stated the loratadine order dated 7/25/21 was inaccurately entered into Resident #101's clinical record. LPN #4 further stated she mistakenly documented administration of the 7/25/21 loratadine order from 7/26/21 through 7/28/21 because she only administered a total of 10 mg of loratadine and administered the medication to Resident #101 via PEG tube. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Administering Medications" documented, "As required or indicated for a medication, the individual administering the medication will record in the resident's medical record: a. The date and time the medication was administered; b. The dosage; c. The route of administration..." No further information was presented prior to exit.	F 842		

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F 842	Continued From page 209 References: (1) Loratadine is used to treat itching and redness. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697038.html (2) Multiple Sclerosis is a nervous system disease that affects the brain and spinal cord . This information was obtained from: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=ms&_ga=2.168269095.727485085.1627513122-1380714373.1627513122 2.b. The facility staff failed to ensure an inaccurate physician's order for prednisone (1) was not entered in Resident #101's clinical record and failed to ensure accurate documentation for administration of the medication. Review of Resident #101's clinical record revealed a physician's order dated 6/17/21 for nothing by mouth. Further review of Resident #101's clinical record revealed a physician's order dated 7/25/21 for prednisone 20 mg (milligrams) by mouth one time a day for a rash until 7/21/21. Review of Resident #101's July 2021 MAR (medication administration record) revealed documentation that prednisone 20 mg was administered by mouth to the resident from 7/26/21 through 7/28/21. On 7/28/21 at 12:27 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the nurse who signed off administration of	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495391	A. BUILDING _____ B. WING _____	C 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 210 prednisone by mouth from 7/26/21 through 7/28/21. LPN #4 stated Resident #101 could not receive medications by mouth and received medications via PEG tube (a feeding tube inserted into the stomach). LPN #4 stated the prednisone order dated 7/25/21 was inaccurately entered into Resident #101's clinical record because it should have documented administration via PEG tube instead of by mouth. LPN #4 further stated she mistakenly documented administration of the medication by mouth from 7/26/21 through 7/28/21 because she administered the medication via PEG tube. On 7/28/21 at 4:52 p.m., ASM (administrative staff member) #1 (the regional director of clinical services) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. Reference: (1) "Prednisone is used alone or with other medications to treat the symptoms of low corticosteroid levels (lack of certain substances that are usually produced by the body and are needed for normal body functioning). Prednisone is also used to treat other conditions in patients with normal corticosteroid levels. These conditions include certain types of arthritis; severe allergic reactions; multiple sclerosis (a disease in which the nerves do not function properly)." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601102.html	F 842		