STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 8/15/21 through 8/17/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/15/2021 through 8/17/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint (VA00052831- unsubstantiated), was investigated during the survey. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 40 Resident reviews.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provision of the federal and state laws require it. This Plan of Correction serves as the facility's allegation of compliance.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.	F 577	F 577 Right to Survey Results 1. The survey results survey ending on 6.23.20 were placed in the survey binder and survey results for NHSN reporting on 1.18.21, 1.25.21, 07.05.21 and 7.12.201. No residents were affected by the deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: Administrator — (X6) DATE: 9/10/21

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 577	Continued From page 1 (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility staff failed to post in a readily accessible place, reports and any plan of corrections in effect with respect to any surveys conducted during the past 3 years for all 109 Residents residing in the facility. The facility's non-compliance has the potential to impact all Residents and their family's ability to make informed decisions with regard to knowledge of the facilities regulatory compliance history. The findings included: On 8/15/21 at 11:15 AM, upon entrance to the facility, Surveyor A observed in the lobby a notice that indicated survey/inspection reports were maintained in a binder on the outside of the Administrator's office. On 8/16/21 at 3:35 PM, Surveyor A went to the lobby and made the following observations of the contents of the survey results binder. The binder contained a survey report with a survey ending date of 6/23/20, the report did not contain the plan of correction the facility implemented to correct the identified deficiencies. In addition, the	F 577	2. All residents have a potential to be affected by the deficient practice. 3. The Executive Director (ED)/Designee will in-service the Business Office Manager (BOM) /Designee on having all survey results within 3 years readily available for review and the policies and procedures for displaying results. 4. The BOM/Designee will conduct an audit on survey binder weekly for 4weeks and report findings to QAPI Committee for 1-months and the committee will be responsible for ongoing monitoring and findings will be reported as needed. 5. 9/29/2021	

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F 577	Continued From page 2 2567's (survey reports) dated 01/18/2021, 01/25/2021, 07/05/2021 and 07/12/2021, were not available for review. On 8/16/21, during an end of day meeting, the facility staff which included the facility administrator and DON (director of nursing) were made aware of the missing survey reports. The facility administrator stated, "I think they are in my survey readiness binder". No further information was provided.	F 577		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the	F 582	F 582 Medicaid/Medicare Coverage Liability Notice 1. Resident #51 did not suffered any adverse effects related to SNF ABN notification of designation. Responsible Party will be contact to get clarification on their SNF ABN designation. All SNF ABN will be reviewed for accuracy and completion.	

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F 582	Continued From page 3 facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for one resident (Resident #51 in the sample of 40 residents) to continue skilled care services following the issuance of a SNF ABN (skilled nursing facility advance beneficiary notice). Resident #51 did not choose to discontinue services. This failure prevented the Resident from excercising her right to continue to receive skilled care services, and have Medicare	F 582	2. All residents have potential to be affected related to SNF ABN notification. A 100% audit will be conducted of the SNF ABN notifications. 3. The ED/Designee will in-service the BOM/SSD in regards to SNF ABN notification and designation selection. 4. The Business Office Manager/ designee will conduct a 100% audit on SNF ABN notification for the last 30-days. Any deficient practice will be corrected and reported to the QAPI committee for 1-month and the committee will be responsible for ongoing monitoring. 5. 9/29/2021	

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F 582	Continued From page 4 make the coverage determination or the Resident pay privately for the services. The findings included: Resident #51, was admitted to the facility on 1/18/19, with a readmission on 3/18/21. Resident #51's diagnoses included but were not limited to: hypertension, renal insufficiency, dementia and Parkinson's disease. Resident #51's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 6/23/21, was coded as a quarterly assessment. Resident #51 was coded as her cognitive skills for daily decision making being moderately impaired with a BIMS (brief interview for mental status score) of 10. The resident was also coded as having required extensive to total assistance of facility staff for activities of daily living (ADL's). Resident #51 was discharged from a Medicare covered Part A stay on 4/2/21, she remained in the facility. On 8/16/21, a review of a sampling of facility record reviews of Medicare discharge notices revealed the facility issued a SNF ABN to Resident #51's representative, the options were blank with no selection chosen. Resident #51 and/or her Resident representative, didn't select an option on the SNF ABN which would have allowed skilled services to continue and have Medicare make the determination or them pay privately for the services; nor did they select for the skilled care services to be discontinued. The facility staff chose to end skilled care services without knowing the Resident's selection of the options.	F 582		

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F 582	Continued From page 5 On 08/16/21 at 02:38 PM, an interview was conducted with Employee L, the Business Office Manager. Employee L stated, "I did these [referring to the NOMNC and SNF ABN forms] because we didn't have a social worker at the time". Employee L was asked what the purpose of the forms are and she said, "To let the resident and family know they no longer meet skilled criteria, no longer have a skilled need or have exhausted their benefits". Employee L was asked to describe the 2 different notices and she stated, "The ABN is when they are going to stay here and when they are going to be responsible for paying private pay or have a patient liability for Medicaid. The NOMNC- tells them their last day of Medicare, it has 3 options, if they want us to continue and bill Medicare and if Medicare determines they are not eligible they would be responsible. Another option is they don't want us to bill and wouldn't be responsible. The last option is, we won't bill Medicare but they still want them to get services". The notices for Resident #51 were reviewed with Employee L. Employee L was asked which option Resident #51 chose on the SNF ABN form, she stated, "A lot of time we tell them and they still don't choose an option. We talked to her on the phone about it and when they come in to sign we leave the forms at the front desk, we give them the form". Employee L was asked how someone would know Resident #51 didn't request a demand bill, where they choose for Medicare to be billed for the services and make the determination if continued skilled care is warranted. Employee L stated, "if they did [choose a demand bill] we would have left them Medicare and would have billed them, when we	F 582		

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F 582	Continued From page 6 talked to her she said she understood. We tell them about the options, they don't always mark the options". 08/16/21 at 03:06 PM, Employee L was asked if the NOMNC and SNF ABN forms for Resident #51 were considered incomplete and she stated, "Yes". Employee L confirmed that the facility follows CMS (Center for Medicare and Medicaid Services) guidance on how to complete the forms. On 8/16/21 at 4:40 PM, a review of the facility policy titled, "Non-coverage and Advanced Beneficiary Notices Policy" was conducted. This policy stated, "[company name redacted] is committed to upholding resident rights and this includes following the guidelines set forth by regulations regarding notices of non-coverage. We want all of our residents and families to be aware of the rights they have under Medicare as well as properly notifying them of what expenses may incur when switching payment sources". CMS identifies when the ABN is required to be issued in their document titled "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)" read, "Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: "Not medically reasonable and necessary; or Considered custodial". "The SNFABN provides information to the beneficiary so that s/he can decide whether or not	F 582		

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F 582	Continued From page 7 to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services". Accessed online at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI The Administrator was informed on 8/16/21, during an end of day meeting that the SNF ABN form was incomplete for Resident #51. No further information was provided.	F 582		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement their abuse policy regarding the screening of employees for 15 employees (Employee B, Employee D, Employee E,	F 607	F 607 Develop/Implement Abuse/ Neglect Policies 1. No resident was affected by the deficient practice. Human Resource Manager (HRM) /Designee will process sworn statements, background checks, reference checks and licensure verification for staff identify by this deficient practice. 2. All residents have a potential to be affected by this deficient practice. A 100% audit will be completed to determine others that may have been affected by this deficient practice.	

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F 607	Continued From page 8 Employee F, Employee G, Employee H, RN A, RN B, LPN A, LPN B, LPN C, CNA A, CNA B, CNA C, and CNA E) in a sample of 25 employee records reviewed. The findings included: On 8/16/21, Surveyor C conducted a review of 25 employee files and revealed the following: 1. The facility staff failed to obtain a criminal background check within 30 days of hire for 8 Employees (Employee D, Employee E, Employee F, Employee G, Employee H, LPN A, LPN C, and CNA C). 2. The facility staff failed to perform professional license verification to ensure nursing employees held current licensure or certification and to determine if they had been subject to disciplinary action against their professional license as a result of abuse, neglect or mistreatment for 8 employees (Employee B, Employee E, Employee F, RN B, LPN A, LPN B, LPN C, and CNA C). 3. The facility staff failed to check references prior to hire for 13 employees (Employee D, Employee E, Employee F, Employee G, Employee H, RN A, RN B, LPN A, LPN C, CNA A, CNA B, CNA C, and CNA E). On 8/16/21, Surveyor C met with the Director of Nursing (DON) to review the findings. The DON confirmed the hire dates for the referenced facility staff members. The DON was asked about the importance of obtaining a criminal background check prior to employment and she stated, "To make sure that we are hiring an employee that has not had any criminal activity that would put	F 607	3. Executive Director (ED)/ designee will re-educate HRM/Designee on the policy and procedure for hiring and ensuring licensure, sworn statements, reference checks and background checks are conducted timely. ED/Designee will sign off on employee files to ensure that they are compliant. 4. ED/designee will implement and monitor new hires files for adherence to the policy. Ten employee files a week will be audited for 4 weeks and reported to QAPI for 1-month and the committee will be responsible for ongoing monitoring. 5. 9/29/2021	

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F 607	Continued From page 9 our facility and residents at risk". The DON was asked about the importance of obtaining a professional license verification prior to employment and she stated, "To be sure that we are hiring qualified staff to provide care and services to our residents, that staff are appropriately certified to perform or provide the services required according to the job that they are applying for in their job description". The DON was asked about the importance of checking references prior to employment and she stated, "To ensure that the people we have working with our residents have behaviors and work ethics that align with the needs of our residents". A review of the facility's policy entitled, "Abuse, Neglect, and Exploitation Policy-Virginia", effective date 05/01/2017, subtitle, "Policy", read in part, "It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents....Furthermore, it is the intent of this facility to employ only properly screened persons as part of the resident care team by the applicable requirements". Also contained within the facility's abuse policy, subtitle, "Procedure", section, "I. Screening:", the following items read, "2. A criminal background check will be completed to meet state requirements, 3. References and/or previous employers will be contacted to verify applicants' work history, performance and other related items, 4. Licensure/registry check will also be performed..." and "6. This facility will not employ individuals who have had a disciplinary action taken against their professional license by a state	F 607		

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F 607	Continued From page 10 licensure body as a result of a finding of abuse, neglect, mistreatment of residents, or misappropriation of their property". The Facility Administrator and Director of Nursing (DON) were made aware of the findings on 8/16/21. No further information was received.	F 607		
F 641 SS=E	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, facility documentation review and clinical record review, the facility staff failed to accurately code an MDS (minimum data set) assessment for four Residents (Residents #11 ,# 54, #11, #84, #33) in a survey sample of 40 Residents. Findings included: 1. For Resident # 11, the facility staff failed to assess the Resident's cognitive functioning in Section C: Cognitive Pattern in the Quarterly Assessment dated 5/11/21. Resident # 11 was a 45 year old admitted to the facility 12/22/2020. Resident # 11's diagnoses included but were not limited to: Diabetic Ketoacidosis, Diabetic ulcers bilateral feet, osteomyelitis and History of Diabetes (Non-compliant).	F 641	F 641 Accuracy of Assessments 1. Residents #11, #54, #11, #84, and #33 did not suffer any adverse reactions from this deficient practice. The Resident Assessment Coordinator (RAC)/ Designee will complete an audit of the most recent MDS submitted for current residents. Any resident with the BIMS interview coded as "not assessed" will have a modified assessment to BIMs completed and documented in the PCC User Defined Assessments. 2. All residents have the potential of being affected by this deficient practice. A 100% audit will be conducted to determine others that may have been affected.	

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F 641	Continued From page 11 The most recent MDS (Minimum Data Set) assessment was a Quarterly Assessment with an ARD (Assessment Reference Date) of 5/11/2021. Review of Section C:Cognitive Pattern revealed Resident # 11 did not have a Brief Interview for Memory score because the cognitive assessment had several sections documented as dashes and "was not assessed." Resident # 11 was coded as requiring the assistance of supervision to limited assistance of one staff person for Activities of Daily Living (ADLs). Review of the Clinical record was conducted on 8/15/2021. Further review of the MDS Assessment with an ARD of 5/11/2021 revealed that under "Section C-Cognitive Patterns -C0100-should Brief Interview for Mental Status be conducted" , the answer "yes" was checked. Under section C, items C0200-C0500, the Resident interview had not been conducted and a dash (-) had been entered.. Sections C0600 through C1000 had dashes and " was not assessed" was written in the area for staff assessment for mental status. On 8/16/2021 at 3:40 PM during an interview, the Director of Nursing was requested to provide the facility policy regarding MDS completion. The Director of Nursing stated the facility staff should complete the assessment 1 day before or on the Assessment Review Date but "never after it." She stated it was important to complete the cognitive assessment timely. The Director of Nursing stated the Resident Assessment Coordinator or MDS coordinator was responsible for completing Section C on the MDS. The Director of Nursing stated the facility was in the process of hiring a	F 641	3. The Regional Resident Care Coordinator/ Designee will provide education to the MDS team on the timing required for completion of section C – BIMs interview in accordance with the RAI guidelines. MDS interviews for section C – BIMS that are not completed on or before the assessment reference date will be coded as "not assessed" indicating that the interview was not completed during the look-back period in accordance with the RAI guidelines. The quarterly assessment, significant change assessment and annual assessments requirements will be fulfilled by completing interviews during the 14 day completion period and documenting resident responses in the PCC user defined assessments. 4. RAC/Designee will audit 8 MDSs for completion of section C BIMs weekly X 4 weeks, then 4 MDSs weekly X 4 weeks, then 4 MDSs monthly x 1 month. Findings will be reported to QAPI for review monthly for 3 months. The results of the audit will be brought to Quality Assurance committee for review and recommendations for 60 days. 5. 9/29/2021	

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F 641	Continued From page 12 new MDS Coordinator. During the end of day debriefing on 8/16/2021, the facility Administrator In Training and Director of Nursing were informed of the findings. On 8/17/2021 at 1:25 PM, an interview was conducted with the Regional MDS Coordinator (Employee I) who stated the facility staff was expected to assess the cognitive patterns of residents during the MDS assessment. Employee I reviewed the clinical record with this surveyor (Surveyor B) and observed Section C (Cognitive Pattern) Sections C0200-C0400 were coded as "not assessed." Employee I stated the expectation was the facility staff would get the interview the day before or the day of the ARD (Assessment Review Date). Employee I stated that if the interview was not obtained, the staff could utilize the UDA (user defined assessment) feature. Review of the clinical record revealed no documentation of an UDA assessment. Employee I stated she did not know why the sections were not assessed and why an UDA was not done prior to .the completion of the MDS assessment within 14 days of the ARD. When asked about the importance of completing the Cognitive Patterns portion of the MDS, Employee I stated "Because the MDS drives our care plan." Employee I stated the facility used the RAI manual for guidance and would use the UDA (user defined assessment) option to complete the Cognitive assessment prior to the signing of the MDS (if the assessment was not completed prior to or on the ARD). Review revealed there was no UDA document related to the cognitive assessment in the clinical record. Employee I	F 641		

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F 641	Continued From page 13 stated she did not see an UDA document in the record. Review of CMS's RAI Version 3.0 Manual CH 3: Overview of Guide to MDS Items page 3-4 read, "Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system. - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed." CMS's RAI Version 3.0 Manual CH 3: Overview of Guide to MDS Items page C2 read, "Coding Tips: Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood. the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items. Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done." Review of the facility's policy entitled "MDS Responsibilities. Effective 11/1/2013, Revised 11/15/2019" revealed the following statements "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents..... The purpose of this policy is to provide guidance for the interdisciplinary assessment. The interdisciplinary assessment shall be completed for all resident (sic) utilizing the guidelines provided in the Resident	F 641		

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F 641	Continued From page 14 Assessment Instrument (RAI). The Minimum data set 3.0 (MDS) will be completed per RAI guidelines based upon oral or written communication, resident/family interview and assessments provided by the IDT team members. Under Procedure: "1. The MDS assessment sections will be completed by the following IDT members" Under Section ,C- Cognitive Pattern was written that the Social Worker or RAC (Resident Assessment Coordinator) would complete that section. The Administrator in Training , DON (Director of Nursing), and Assistant Director of Nursing were informed of the failure of the staff to complete Section C100-C1000 accurately for a quarterly MDS during the end of day debriefing on 8/17/2021. No further information was provided. 2. For Resident # 54, the facility staff failed to assess the Resident's cognitive functioning in Section C: Cognitive Pattern on the Minimum Data Set Annual Assessment dated 6/30/2021. Resident # 54 was a 66 year old admitted to the facility on 3/14/2018. Resident # 54's diagnoses included but were not limited to: Spinal Cord Injury, Quadriplegia, Peripheral Vascular Disease,	F 641		

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F 641	Continued From page 15 Anemia, Depression and Gastroesophageal Reflux Diesease. The most recent Minimum Data Set, which was an Annual Assessment with an Assessment Reference Date of 6/30/2021 was reviewed. There was no BIMS (Brief Interview for Memory Status) score because the cognitive functioning section was not assessed. Resident # 54 was coded as requiring limited to total assistance of one to two staff persons for Activities of Daily Living (ADLs). Review of the Clinical record was conducted on 8/16/2021. Review of the Minimum Data Set Assessment revealed Resident # 54 was not assessed for cognitive functioning on the annual assessment with an ARD date of 6/302021. Review of Resident # 54 's MDS section C: Cognitive Patterns revealed that for items C0200-C0500, the Resident interview had not been conducted and a dash (-) had been entered. Section C, questions C0600-C1000, also had a dash (-) entered and the statement "was not assessed." Questions C0600-C1000 were for the staff assessment for mental status. On 8/16/2021 at 3:40 PM during an interview, the Director of Nursing was requested to provide the facility policy regarding MDS completion. The Director of Nursing stated the facility staff should complete the assessment 1 day before or on the Assessment Review Date but "never after it." She stated it was important to complete the cognitive assessment timely. The Director of Nursing	F 641		

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F 641	Continued From page 16 stated the Resident Assessment Coordinator or MDS coordinator was responsible for completing Section C on the MDS. The Director of Nursing stated the facility was in the process of hiring a new MDS Coordinator. During the end of day debriefing on 8/16/2021, the facility Administrator In Training and Director of Nursing were informed of the findings. On 8/17/2021 at 1:25 PM, an interview was conducted with the Regional MDS Coordinator (Employee I) who stated the facility staff was expected to assess the cognitive patterns of residents during the MDS assessment. Employee I reviewed the clinical record with this surveyor (Surveyor B) and observed Section C (Cognitive Pattern) Sections C0200-C0400 were coded as "not assessed." Employee I stated the expectation was the facility staff would get the interview the day before or the day of the ARD (Assessment Review Date). Employee I stated that if the interview was not obtained, the staff could utilize the UDA (user defined assessment) feature. Review of the clinical record revealed no documentation of an UDA assessment. Employee I stated she did not know why the sections were not assessed and why an UDA was not done prior to .the completion of the MDS assessment within 14 days of the ARD. When asked about the importance of completing the Cognitive Patterns portion of the MDS, Employee I stated "Because the MDS drives our care plan." Employee I stated the facility used the RAI manual for guidance and would use the UDA (user defined assessment) option to complete the Cognitive assessment prior to the signing of the MDS (if the assessment was not completed prior	F 641		

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F 641	Continued From page 17 to or on the ARD). Review revealed there was no UDA document related to the cognitive assessment in the clinical record. Employee I stated she did not see an UDA document in the record. Review of CMS's RAI Version 3.0 Manual CH 3: Overview of Guide to MDS Items page 3-4 read, "Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system. - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed." CMS's RAI Version 3.0 Manual CH 3: Overview of Guide to MDS Items page C2 read, "Coding Tips: Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood. the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items. Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done." Review of the facility's policy entitled "MDS Responsibilities. Effective 11/1/2013, Revised 11/15/2019" revealed the following statements "It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents..... The purpose of this policy is to provide guidance for the interdisciplinary	F 641		

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F 641	Continued From page 18 assessment. The interdisciplinary assessment shall be completed for all resident (sic) utilizing the guidelines provided in the Resident Assessment Instrument (RAI). The Minimum data set 3.0 (MDS) will be completed per RAI guidelines based upon oral or written communication, resident/family interview and assessments provided by the IDT team members. Under Procedure: "1. The MDS assessment sections will be completed by the following IDT members" Under Section ,C- Cognitive Pattern was written that the Social Worker or RAC (Resident Assessment Coordinator) would complete that section. During the end of day debriefing on 8/17/2021, the facility Administrator in Training , Director of Nursing and Assistant Director of Nursing were informed of the findings. No further information was provided. 3 . For resident # 84 the facility failed to perform the cognitive assessment (Section C) on the MDS (minimum data set). Resident # 84, 72-year-old man was admitted to the facility on 4/7/21 with diagnoses of but not limited to amputation anemia heart, renal insufficiency, obstructive uropathy, diabetes and high cholesterol.	F 641		

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F 641	Continued From page 19 Resident # 84's most recent MDS (mini minimum data set) with an ARD (assessment reference date) of 7/15/21 did not assess the residence BIMS (brief interview of mental status). The MDS coded the resident as (3) extensive assistance of (3) two person physical assistance for bed mobility and transfers. The resident is coded as (4) total dependence with (3) two person physical assistance for local motion on and off the unit for dressing for toilet use, personal hygiene and bathing. The resident needs extensive assistance with one person for eating. The resident is unable to walk he uses a wheelchair for mobility On 817/21 during clinical record review it was noted that the resident had an MDS that was completed on 7/15/21 coded as a quarterly review that was missing the cognitive assessment or section C of the MDS. On 08/17/2021 at 1:25 P.M., an interview with Employee I, the MDS Regional Coordinator, was conducted. When asked about the expectation for the assessment of cognitive patterns, Employee I stated the expectation is to get the interview the day before or the day of the ARD date. When asked why Sections C0200-C0400 were coded as "not assessed" Employee I indicated she did not know why it wasn't done. When asked why it's important to complete the Cognitive Patterns portion of the MDS, Employee I stated "Because MDS [assessments] drive our care plan." On 8/17/21 during the end of day conference the	F 641		

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F 641	Continued From page 20 Administrator was made aware of concerns (via phone call) and no further information as provided	F 641		

4. For Resident #33, the facility staff failed to assess Resident #33's cognitive patterns.

Resident #33, a 49-year old male, was admitted to the facility on 09/03/2019. Diagnoses included but were not limited to multiple sclerosis and depression.

Resident #33's most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/03/2021 was coded as a quarterly assessment. The Response in Section C0100 entitled, "Should Brief Interview for Mental Status (C0200-C0500) be Conducted?" was coded as "1" meaning "Yes." The Responses in Sections C0200-C0400 were coded as "not assessed." Section C0500 entitled, "BIMS [Brief Interview for Mental Status] Summary Score" was blank.

On 08/17/2021 at 1:25 P.M., an interview with Employee I, the MDS Regional Coordinator, was conducted. When asked about the expectation for the assessment of cognitive patterns, Employee I stated the expectation is to get the interview the day before or the day of the ARD date. This surveyor and Employee I observed in Resident #33's clinical record Section C [Cognitive Patterns] quarterly Minimum Data Set dated 06/03/2021. When asked why Sections C0200-C0400 were coded as "not assessed"

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F 641	Continued From page 21 Employee I indicated she did not know why it wasn't done. When asked why it's important to complete the Cognitive Patterns portion of the MDS, Employee I stated "Because MDS [assessments] drive our care plan." On 08/17/2021, the administrator and DON were notified of findings and submitted no further documentation or information.	F 641		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645	F 645 PASARR Screening MD/ID 1. PASARR for resident #22 and resident #207 were completed. No adverse reactions were noted related to PASARR not being completed timely 2. All residents have potential to be affected. A 100% audit of PASARR will be completed on new admissions with the last 30-days 3. ED/designee will re-educate social service and director of admissions on obtaining PASARR prior to admission or at admission and referral to Level II as needed. PASARRs will be completed and referrals for Level II will be completed as needed for other residents identified. 4. ED/designee will monitor new admissions within the last 30-days to ensure that PASARRs are obtained on all admissions weekly for 4 and findings will be brought to QAPI committee for review and recommendations for 60 days. 5. 9/29/2021	

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F 645	Continued From page 22 and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.	F 645		

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F 645	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to obtain a PASARR (pre-admission screening) for 2 Residents (Resident #22 and Resident #207) in a sample of 40 Residents. This deficient practice has the potential to negatively impact both Residents, by failing to have a level I PASARR, the facility staff were not aware if the 2 Residents required a level II screening to determine if specialized services for the treatment of/for mental disorders and/or intellectual disabilities was warranted. 1. For Resident #22 the facility staff failed to obtain a PASARR, level I screening prior to admission. 2. For Resident #207 the facility staff failed to ensure a PASARR was completed prior to entry to the facility. The findings included: 1. For Resident #22 the facility staff failed to obtain a PASARR, level I screening prior to admission. Resident #22 was admitted to the facility on 8/31/17. Diagnoses for Resident #22 included but were not limited to: unspecified dementia with behavioral disturbance, unspecified psychosis, and gastro-esophageal reflux disease without esophagitis. Resident #22's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 5/23/21, was	F 645		

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F 645	Continued From page 24 coded as an annual assessment. Resident #22 was coded as having had a BIMS (brief interview for mental status) score of 12, which indicated moderately impaired cognition. Resident #22 was also coded as having required supervision of facility staff for assistance with ADL's (activities of daily living). On 8/16/21 and 8/17/21, a review of the entire electronic and physical clinical records for Resident #22 was conducted. A PASARR was not able to be found. The facility staff was asked to provide any evidence of Resident #22 having had a PASARR prior to admission. On the afternoon of 8/17/21, the facility staff provided Surveyor A with a PASARR level I screening that was incomplete for Resident #22. All of the questions on the level I PASARR were blank and a note was written at the top of the form that read, "Not required due to dementia diagnosis". The form was not signed as to who wrote this note or when. On 8/17/21 at 1:33 PM, an interview was conducted with Employee J, the social worker. Employee J stated, "When I first got here [a few months ago] I was directed to do a PASARR audit. My understanding was, if a Resident has a diagnosis of dementia they didn't need a PASARR, there was nothing in the previous file for her [Resident #22] so I filed this form so I would know why she didn't need one". Employee J was shown the form and that the questions were all blank, Employee J said, "I now know to answer all of the questions on the form". DMAS (The Department of medical Assistance Services) provides the following directive with regard to Level I PASARR screenings in their	F 645		

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F 645	Continued From page 25 "FREQUENTLY ASKED QUESTIONS: SCREENING CONNECTION CALLS Medicaid LTSS Screening Assistance Updated 4.1.2020" on page 6-7: "A level 1 Screening is really a screening for mental illness (MI), intellectual disability (ID) and related conditions. EVERY individual who seeks admission to a Medicaid-certified facility MUST be screened for MI, ID or related conditions. The individual's financial status is NOT a factor. It is the status of the nursing facility. For individuals who are private pay or would not have a Medicaid LTSS Screening due to one of the Special Circumstances, it is incumbent on the nursing facility to have a process for obtaining a PASRR Level I Screening (and if needed, Level II evaluation and determination) PRIOR to NF admission". Information accessed online at: https://www.dmas.virginia.gov/media/1292/screeningconnection-q-and-a-updated-412020.pdf On 8/17/21, during the end of day meeting, the facilityAdministrator and Director of Nursing, were made aware of the Level I PASARR being blank for Resident #22. No further information was provided. 2. For Resident #207 the facility staff failed to ensure a PASARR was completed prior to entry to the facility. Resident # 207 A 56-year-old woman who was admitted to the facility on 8/13/21 with diagnoses of but not limited to Hemiplegia and hemiparesis following a CVA affecting the left non-dominant side, essential primary hypertension,	F 645		

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F 645	Continued From page 26 schizoaffective disorder, type II diabetes with peripheral neuropathy. Resident had only been in the facility for 3 days therefore she did not have completed MDS. Per her admission assessment Resident # 207 requires no help for bed mobility, she needs supervision only for transfers, and she is independent with eating, supervision only for toileting. And for bathing and hygiene she needs supervision. Her mobility is documented as a wheelchair no assistance needed however she is documented as non-ambulatory. She is documented as needing minimum assist with a gait belt may use a walker for transfers. While this Resident did not have a BIMS score available she was screened in the Admission Assessment as "alert and oriented" and is her own Responsible Party. The Resident has exercised her right to refuse pneumonia vaccine, the flu vaccine as well as the Covid vaccine and was admitted to the isolation/observation unit. On 8/17/21 a review of the clinical records revealed that the resident did not have a PASARR in electronic health record, nor was it in the hard chart on the unit. A request was made to the social worker for the PASARR. The facility provided the Virginia Uniform Assessment Instrument however the PASARR section was missing from the document. When notified the PASARR was not included in the UAI that was submitted she stated "that is all we have on file." The last page of the UA I read as follows: "DMAS 96 Medicaid-funded long term care authorization" "Level I ALF screener [RN name redacted] Date 4/13/17"	F 645		

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F 645	Continued From page 27 "UAI signatures part a page 12" "Assessment completed by [assessors name redacted] Date 4/17/17' 'DMAS screening for mental illness MR/ID or related conditions' "Signature and title [not signed] DATE [not filled in] On 8/17/21 at the end of day meeting the Administrator was made aware and no further documentation was provided.	F 645		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review, the facility staff failed to provide incontinence care in a timely manner for 1 (Resident # 92) in a survey sample of 40 residents. The Findings included: For Resident #92, the facility staff failed to answer the call bell and provide incontinence care in a timely manner. Resident #92, was a 58 year old who was admitted to the facility on 7/25/21. The diagnoses	F 677	F 677 ADL Care Provided for dependent Residents 1. The call bell was answered for resident #92. No resident was affected by this deficient practice. 2. All residents have the potential to be affected. 3. The DON/Designee will educate facility RNs, LPNs, and CNAs staff on the importance of ensuring call bells are answered within 15 minutes to address resident needs. 4. DON/designee will conduct 10 call bell response time audits 5 x a week for 4 weeks and findings will be reported to QAPI committee for 2-months and once a week for 4-weeks for 1-month and the findings will be brought to QAPI for review and recommendations for 1 month. 5. 9/29/2021	

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F 677	Continued From page 28	F 677		

included history of a stroke, coronary artery disease, heart failure, hypertension, high cholesterol, hemiplegia or hemiparesis from stroke, seizure disorder, anxiety disorder, COPD, and depression.

Resident # 92's most recent MDS (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of seven, indicating severe cognitive impairment. The resident was also coded as requiring the extensive physical assistance of two people for bed mobility. Resident #92 is coded as requiring total the dependence of 2 people for transfers, dressing, toilet use, personal hygiene, and bathing. She requires supervision for meals, and uses a wheelchair with assistance of one person. She has upper as well as lower extremity weakness on one side.

On 8/15/21, Surveyor D made the following observations:

11: 25 AM Resident yelling "Nurse! Help! Nurse." Resident # 92's call light was on surveyor went down to room 227 and stood outside. The resident continued yelling out, Surveyor D went towards the nurse's station to see if the call bell was actually sounding at the nurse's station. Halfway down the hall the surveyor could hear the bell ringing. At the nurses station there was an agency nurse sitting at the desk and on the panel behind her room 227 was lit up indicating the call light was on.

11:32 AM resident was heard yelling "Help! I can't breathe nurse, help I can't breathe." Surveyor D looked into room observed resident safely lying in bed.

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F 677	Continued From page 29 11:35 AM the Resident was yelling and banging on her bedside table. At this time 2 laundry staff were in the hall moving the linen carts out of the hallway, one CNA went into a room with no light on (room. 221) came out of there and went into (room 222). At 11:38 AM the resident was coughing and still yelling help. 11:41 AM the resident began banging her cup on the table yelling "help" the call light remained on and the beeping could be heard in the hallway. 11:42 the surveyor walked up to the nurse's station a rea and could still hear resident yelling "help." 11:43 CNA went into room 221 while patient in room 227 was still yelling nurse. 11:45 LPN D the agency nurse at the desk was asked which CAN was assigned the 200's hallway and she said "I don't know I'm agency." When asked if she could look on the schedule she stated "Oh that would be either CNA G or H." 11:55 the Resident was still yelling 11:57 CNA H came down the hall heard resident yelling put on PPE and went into the room. When she came out of the room she was Carrying a clear plastic bag with a soiled incontinent briefs inside she placed her PPE in the red bin outside the Resident #92's door and carried the bag with the incontinent brief to another trash can. 12:05 an interview was conducted with CNA H and she was asked why Resident #92 was yelling. She stated she needed to be changed. When asked what she was doing prior to going into Resident #92's room, CNA H stated "I was on my lunch break." She was asked what the procedure was for getting her patients covered	F 677		

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F 677	Continued From page 30 while she was on break, and she responded "I tell the nurse and she handles it." On 8/15/21 at 1:30 PM, an interview was conducted with a DON who stated the CNA's do report off to the nurse, however all staff are expected to answer call lights whether those Residents are assigned to them or not. On 8/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility documentation, the facility staff failed to provide services to prevent pressure ulcers, for 1 Resident (#36) in a survey sample of 40 Residents. The Findings included:	F 686	F 686 Treatment/Services to Prevent/Heal Pressure Ulcers 1. Resident #36 had a skin assessment completed. No resident was affected by this deficient practice. 2. All residents have the potential to be affected. A 100% audit of resident skin will be completed to identify all that may be affected by this deficient practice.	

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F 686	Continued From page 31 For Resident #36 the facility staff failed to prevent a pressure area from developing from wearing tight shoes. Resident #36 was a 64-year-old who was admitted to the facility on 9/14/20. Resident #36's diagnoses included stroke, high, cholesterol, difficulty walking, muscle weakness and long term current use of steroids. Resident #36's most recent MDS (minimum data set) with an ARD (assessment reference date) of 6/8/21, coded the Resident has having a BIMS (brief interview of mental status) score of 11 out of 15 indicating moderate cognitive impairment. Resident #36 was also coded as requiring the extensive physical assistance of two people for bed mobility, transfers, and toilet use. He is coded as requiring the extensive physical assistance of one person for dressing, personal hygiene, eating and bathing. The Resident does not stand and bear weight, he is non-ambulatory, uses a wheelchair for mobility, but is able to self-propel. On 8/15/21 at approximately 2:00 PM during clinical record review, it was noted that Resident #36 had a wound to his right great toe. The wound was discovered on 5/12/21 and measured 1 cm x 1 cm x 0.5 cm. A review of the clinical record revealed in the progress notes read: "5/12/21 at 9:15 PM, during skin check rounds resident was noted to have open area to his right great toe measuring 1.0 x 1.0 x 0.5 cm. scant drainage. Resident states that when he wears his	F 686	3. Director of Nursing (DON)/designee will re-educate all RN, LPN, and CNA facility staff of the importance of skin assessments to prevent wound development, rounding on turning and repositioning, ensuring incontinent care is performed timely, and performing treatments as ordered by Doctor/Nurse Practitioner. 4. DON/designee will perform 5 weekly skin audits 3x a week for 4 weeks, and then 5 skin audits weekly for 4 weeks and the finding will be brought to QAPI for 2-months for the committee to review. 5. 9/29/2021	

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F 686	Continued From page 32 shoes they feel tight [Nurse practitioners name redacted] aware. New orders for meta-honey and dressing daily will also contact family for a bigger size shoes. Resident is on RP and aware." SBAR was sent to physician via Convergence [Convergence is a messaging system used by facilities to contact providers after hours]. The SBAR read: "5/12/21 at 9:15 PM Convergence Narrative Situation: right great toe wound Background: B/ P 132/75, SP0: 98 L of oxygen; HR 74 respiratory rate 18 temperature 98.3. Patient has a new open area on his right great toe. Wound appears to be pressure related to tight shoes per patient. Wound specialist was contacted and ordered apply meta-honey and a dry dressing daily and follow up wound provider in the am. Assessment: right great toe wound Plan: continue to monitor and notify convergence for any changes of condition follow up with rounding skilled nursing facility provider on next business day." The document "Skin Grid Pressure - V8" read as follows: "[Resident name redacted] skin grid pressure- V8 date 5/12/21 at 9:15 PM Skin condition information Is this a new pressure area? (1) Yes Resident refuse skin assessment? (B) No Date area was first observed - 5/12/21 House/community acquired number one house acquired - (1) House	F 686		

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F 686	Continued From page 33 Risk factors - Limited mobility Additional risk factors- CVA Site #51 right toe pressure length 1.0 cm width 1.0 cm depth 0.5 cm Is there a suspected deep tissue injury (2) No Edges (2) distinct outline clearly visible, attached, even with the wound base Appearance of wound bed select all that apply (2) Epithelialization tissue present Color of wound bed (2) Reddened Exudate amount (3) blood tinged Drainage (a) small amount Odor (b) No Peri-wound appearance (1) pink normal for ethnic type Is tunneling present- No Does resident have pain associated with wound (2) No Has the care plan been reviewed and revised as necessary - yes Additional information or comments cleanse with normal Saline apply meta-honey and dry dressing." The resident was seen on 5/14/21 by the nurse practitioner who ordered continue meta-honey Dressing and Keflex antibiotic and follow up with wound nurse practitioner. "On 5/14/21 at 2:49 PM spoke to residents emergency contact #1 [contact name redacted] to ask him to bring resident larger shoes for comfort. Per [contact name redacted] he will be purchasing [Resident #36 name redacted] new shoes for comfort." On 5/16/21 at 4:10 PM the resident was seen by	F 686		

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F 686	Continued From page 34 the wound care nurse practitioner notes stated that the wound nurse practitioner performed a surgical debridement of the wound and "post debridement of the wound it measured 0.85 x 0.93 x 0.2 cm." [Smaller than when originally found 5/12/21] A review the care plan record that read: "FOCUS [Resident # 36's name redacted] is at risk for pressure ulcer due to limited mobility Date Initiated: 1/30/17 Revision on: 6/23/19. GOAL [Resident name redacted] will remain free from skin breakdown through Next review. Date Initiated 1/9/18 Revision On: 2/17/20 target date 6/16/21 INTERVENTIONS: Complete Braden scale per living center policy Date Initiated: 1/30/17 Provide pressure reducing wheelchair cushion Date Initiated: 1/30/17 Pressure reduction/relieving mattress Date Initiated: 1/30/17 Provide thorough skin care after incline episodes and apply barrier cream Date Initiated: 1/30/17 Treatments as ordered. Date Initiated: 1/30/17 [Resident name redacted] right great toe will show improvement by having decreased in size by next review. Date Initiated: 5/14/21 Target Date: 6/16/21 FOCUS: [Resident name redacted] has impaired skin and is risk for further skin breakdown or/T limited mobility open area to right great toe secondary to friction from shoe Date Initiated:4/8/19 Revision	F 686		

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F 686	Continued From page 35 on : 5/14/21 Goal Mr. Thorne will be free from further skin breakdown through the review date. Date Initiated: 4/8/19 INTERVENTIONS: Apply moisture barrier to skin cream is needed do not massage over bony promises use mild cleansers for Peri- washing Date Initiated: 4/18/19 Revision on 6/25/19 Family contacted and plan to purchase large issues for comfort Date Initiated: 5 /14/21" On 8/16/21 an interview with CNA F was conducted and she was asked if she routinely checks the Residents feet when getting them dressed. She indicated that if she was putting on socks or bathing the Resident then she would report anything unusual to the nurse. She was asked what she would do if a Resident had shoes that did not fit well and she responded "if the Resident complained that his feet hurt I would tell the nurse." On 8/17/21 during the end of day meeting the Administrator was made aware of the concern via phone call and no further information was provided.	F 686		
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.	F 732	F 732 Post Nursing Staffing Information 1. Staffing information was updated and placed at the nurse's stations and in the reception area. No resident was affected by deficient practice.	

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F 732	Continued From page 36 (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. (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 and staff interview, the facility staff failed to post the daily nursing staffing on 1 of the 3 days survey was conducted. This non-compliance has the potential to affect all 109 Residents residing in the facility by not allowing them and/or their representatives to have	F 732	2. No residents affected by the deficient practice. 3. ED/designee will re-educate staffing coordinator, receptionist and nurse supervisor on updating and posting the current staffing data in the facility daily. 4. ED/designee will perform audits 5 x week for 4 weeks and 2xs a week for 4 weeks to ensure current staffing information is posted for visitors and residents the results will be brought to QAPI committee for 2-months for review and then quarterly for 1-month. 5. 9/29/2021	

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F 732	Continued From page 37 knowledge of the facility's nurse staffing levels. The findings included: On 8/15/21 at 11:15 AM, upon entrance to the facility, Surveyor A observed the daily nursing staff posting outside of the Administrator's office in the facility lobby. Further review of this document revealed that the date of the posting and data contained within was from 8/13/21. On 8/15/21 at 4:45 PM, during an end of day meeting the facility administrator and director of nursing were made aware that the daily staff posting had not been updated since 8/13/21. The facility administrator confirmed that it is to be updated daily. On 8/17/21 at 1:00 PM, Employee D (administrator in training) identified Employee K, the scheduling coordinator as the employee responsible for the daily staffing posting. On 8/17/21 at 1:23 PM, Employee K was asked about the nursing staffing posting. Employee D stated, "On the weekends it is not posted, I update it on Mondays". When asked what her understanding of the posting requirement is, Employee K stated, "So we know who and how many we have in the building and our census". When asked what her understanding was of the frequency of posting, Employee K said, "the requirement is Monday-Friday, the old staffing coordinator trained me on it". No further information was provided.	F 732		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745	F 745 Provision of Medically Related Social Services 1. Resident #207 was visited by the social worker/designee. No resident sustained was affected by this deficient practice.	

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	495252	A. BUILDING _____ B. WING _____	C 08/17/2021

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F 745	Continued From page 38 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation, and clinical record review, the facility staff failed for 1 Resident #207 to provide medially-related social services to attain or maintain highest practicable mental and psychosocial well-being. The findings included: For Resident #207, the facility staff failed to have her seen by the Social Worker in a timely manner when she was when she was asking to leave. Resident #207 failed to comply with isolation, and had a known diagnosis of schizoaffective disorder, She was her own responsible party. Resident #207, a 56-year-old, was admitted to the facility on 8/13/21 with diagnoses of but not limited to hemiplegia and hemiparesis following a CVA affecting the left non-dominant side, essential primary hypertension, type II diabetes with peripheral neuropathy, schizoaffective disorder, and depression. Resident #207 had only been in the facility for 3 days, therefore she did not have a completed MDS (Minimum Data Set). Per her admission assessment Resident #207 required no help for bed mobility, she needed supervision only for transfers, toileting, bathing and hygiene. Her mobility was documented as requiring a wheelchair for ambulation. While this Resident	F 745	2. All residents have the potential to be affected. A 100% audit of new admissions within the last 30-days will be conducted to determine others that may have been affected by this deficient practice. 3. ED/designee will re-educate social service and admission staff on the importance of visiting with new residents 48-hours and began discharge planning. 4. ED/designee will monitor that all new admission are visited with 48-hours of admission 3xs a week for 4 weeks and the findings will be brought to QAPI committee for review and recommendations for 1-month. 5. 9/29/2021	

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F 745	Continued From page 39	F 745		

did not have a BIMS score available she was screened in the Admission Assessment as "alert and oriented" and is her own Responsible Party. The Resident has exercised her right to refuse pneumonia vaccine, the flu vaccine, the Covid vaccine, and was admitted to the isolation/observation unit.

On 8/15/21 at approximately 4:00 PM an interview was conducted with Resident #207, who stated "I want to get out of here, I am not even sure why they are keeping me here. I want to go home." When asked why she is here she stated "I don't know but they won't let me out of here." She stated that the "Police" brought her to the facility after she went to the "bus station."

In the absence of the Administrator the DON was notified of the Resident's comments to the surveyor immediately after the Resident interview ended. The DON stated she would go and visit the Resident and see if she could be of help.

On 8/16/21 at 4:55 PM a review of the clinical record was completed and there were no progress notes addressing the Resident's concerns.

On 8/16/21 5:00 PM and interview was conducted with the Social Worker about Resident #207's desire to leave the facility. The Social Worker stated she had not met the Resident. She stated that all she knew about her [Resident 207] was what she was told in report. When she was told the Resident expressed a desire to leave the facility she stated, "Well I haven't had a chance to meet her so I don't feel I can speak on it." The Social worker agreed to speak with the Resident and then meet with surveyors the following day to

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F 745	Continued From page 40 discuss Resident #207. On 8/17/21 a review of the clinical record revealed the following note from the Social Worker: "8/16/21 at 9:15 PM - Social Worker -completed initial social history with resident. Resident wishes to discharge as soon as possible, and requested to this writer call her daughter [daughters name redacted] in the morning 8/17/21 to make arrangements for discharge while also agreeing to remain in the Facility for the remainder of the night. Prior to admission, resident was homeless for one week after a misunderstanding with other daughter, [daughters name redacted]. The resident has the following diagnoses and passed Medical history: hemiplegia and hemiparesis following a cerebral infarction affecting the non-dominant left side; essential hypertension; schizoaffective disorder, unspecified diabetes type two with diabetic neuropathy, major depressive disorder, recurrent unspecified anxiety disorder and hyperlipidemia. Throughout the social history assessment resident appears to be experiencing visual hallucinations, as she asked writer who was flashing a light into the room several times when there was no flashing light. Resident also reported to this writer that she believes her daughter's boyfriend was poisoning her food with drugs while she was living with them. Resident met made the statement that she sometimes wishes she could die; however she contracted for safety and indicated that she does not have a plan or intent to harm herself. Resident provided verbal consent for services with legacy healthcare. Nursing staff notified and referral was made to [psychiatric service name redacted]. Writer reviewed the residence code	F 745		

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F 745	Continued From page 41 status with the resident. The resident is a full code. Writer reviewed the right to establish and execute advance directives for healthcare resident advised writer that at this time she wishes not to establish an advance directive, and writer provided her with information. Residence goal is to return to the community as quickly as possible. Writer addressed and answered any additional questions, and or concerns and encourage the resident to reach out as needed. SW to continue to monitor and provide support as needed." On 8/17/21 at approximately 2:00 PM an interview was conducted with the Social Worker and the DON. The Social Worker was asked what expectation is for completing the Resident admission screening she stated usually within 72 hours. The DON interjected that after talking to the Surveyor on Sunday 8/15/21, she went to the Resident and spoke with her and got her some snacks and something to do, and she spoke with her about needing to have plan for leaving and that it would not be safe to just leave without a safe place to go to. The Resident agreed to stay "for now" and give the facility a chance to get a discharge plan started. The Social Worker stated the DON told her not to go in and see her on Sunday (8/15/21) to do the Admission Screening because she had gotten the Resident calmer and agreeing to stay "for now." When asked why she did not go back on Monday morning as opposed to 9:15 PM she stated "I had meetings all day on Monday."	F 745		

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F 745	Continued From page 42 She was asked about the mental health of Resident #207, as in her note she stated the Resident made a statement of SI (suicidal ideation) and the Resident has a diagnosis of schizoaffective disorder, depression and is her own RP. The Social Worker stated that the Resident contracted for safety that she had no plan or intent to harm herself. The social worker was asked if she had seen the resident since the initial interview at 9:15pm on 8/16/21 and she indicated that she had not. When asked if she had called the daughter as she stated in her note she indicated that she had not gotten around to it yet. When she was asked when the Resident would be seen by psychiatric services she stated "They come every Friday." She was asked if they come more frequently for more urgent cases or crisis intervention and she stated they could. On 8/17/21 during the end of day conference the Administrator was made aware of the concerns (via telephone) and no further information was provided.	F 745		
F 814 SS=F	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 and staff interview, the facility staff failed to dispose of garbage properly in one of three trash receptacles (dumpster near the small employee parking lot) outside the facility. On 8/16/2021 at 8:30 AM, the large garbage dumpster near the smaller staff parking lot on the	F 814	F 814 Dispose Garbage and Refuse Property 1. The dumpster is scheduled for pickup. No resident was affected by this deficient practice.	

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F 814	Continued From page 43 right side of the facility was observed with several white trash bags and cardboard boxes visible at least twelve inches above the level of the top of the dumpster. There was no cover over the top of the dumpster. There was debris on the ground around the dumpster. The debris consisted of several pieces of paper, and gloves. On 8/16/2021 at 10:57 AM, further inspection of the dumpster revealed several rusted holes in the front and sides and several flies were seen on top of the bags of trash visible above the top of the dumpster. Inside the bags, containers of orange juice, other food items and blue pads were observed. There was a very foul odor emanating from the dumpster. There was an odor of urine and feces noted. On 8/17/2021 at 8:20 AM, the garbage dumpster again was observed with bags above the level at the top. Surveyor B and Surveyor F observed the garbage dumpster. There was a blue mattress observed on top of some of the white bags. The weight of the mattress appeared to have pushed some of the bags down into the dumpster. The mattress and bags were still above the top of the dumpster and no cover was observed. On 8/17/2021 at 1:15 PM, an interview was conducted with the Maintenance Director during a tour of the staff parking lot and garbage receptacle. The Maintenance Director stated the garbage dumpster was routinely scheduled for collection weekly on Thursdays. The Maintenance Director stated he was not aware of the need for that particular dumpster to be covered. He stated the receptacles (dumpsters) near the kitchen were kept covered but not the	F 814	2. All residents have the potential to be affected. 3. ED/designee will re-educate maintenance director/ designee on proper disposal of garbage and refuse and keeping area free of debris. 4. Maintenance Director /designee will audit the dumpster 5xs a week for 4 weeks to ensure that garbage is dispose of properly and the grounds are free of debris and then weekly for 1-month and the findings will be brought to QAPI committee for review and recommendations for 2-months. 5. 9/29/2021	

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F 814	Continued From page 44 one on the opposite side of the facility. The Maintenance Director stated debris should not be around the garbage receptacle because it could cause pests. During the end of day debriefing, the Administrator in Training, Director of Nursing and Assistant Director of Nursing were informed of the findings. No further information was presented.	F 814		