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

PRINTED: 07/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495392	A. BUILDING _____ B. WING _____	C 07/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEALTH & REHAB CENTER, LLC	1604 OLD DONATION PKWY VIRGINIA BEACH, VA 23454

(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 07/06/21 through 07/08/21. 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 07/06/21 through 07/08/21 significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 5 complaints were investigated during the survey. (Including 1 complaint facility to facility). The census in this 90 certified bed facility was 64 at the time of the survey. The survey sample consisted of 41 current Resident reviews and 3 closed record reviews.	F 000	**F 550** **1. Resident #25 hair was washed, groomed and personal clothing was made available for resident to select which items of clothing she would like to wear.** **2. Current residents have the potential for not having hair washed and personal clothing not available for them to wear. Audit completed to identify any concerns and areas addressed as appropriate.** **3. Nursing staff educated on providing ADL care including hair care and facility staff educated on resident rights including selecting which clothes to wear by Director of Nursing/designee. Education will be provided to agency staff and new nursing employees during orientation.** **4. Administrator/designee will interview 5 residents weekly for 12 weeks for concerns regarding grooming and clothing. Director of Nursing/designee will observe 5 non interviewable residents weekly for 12 weeks for any grooming or clothing concerns. Results of audits will be taken to QAPI committee monthly X 3 for review and revision as needed.**
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		

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AUG 03 2021
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8-9-21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashlee Pease
TITLE: Administrator
(X6) DATE: 7/29/2021

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, clinical record review, staff and resident interviews, the facility staff failed to ensure dignity was maintained for 1 of 41 residents (Resident #25) in the survey sample to wear personal clothing, wash and cut hair. The findings included: Resident #25 was admitted to the nursing facility on 3/23/17 with diagnoses that included type II	F 550		

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F 550	Continued From page 2 diabetes mellitus, stroke with right sided hemiplegia and hemiparesis and expressive aphasia, depression, high blood pressure and non-Alzheimer's dementia. The resident's most recent Minimum Data Set (MDS) assessment was a quarterly and coded Resident #25 with clear speech, able to understand the staff and was understood by them. She was coded on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15, which indicated she was cognitively intact with the skills needed for daily decision-making. She was coded as having no problems with behavior and mood. The resident required extensive assistance of one staff for personal hygiene. She was impaired on one side, upper and lower, in range of motion. The wheelchair was her primary mode of transportation. The resident was coded not to reject care. The care plan dated 5/11/21 identified that resident was showing depression. The goal set for the resident by the staff included the resident would initiate and engage in positive experience and maintain psychological well-being, positive expressions and positive body language. Some of the interventions the staff would implement to accomplish this goal included encourage expressing feelings, listening with empathy and non-judgmental acceptance and compassion, encouraging self-expression and timing to do so as needed. The following observations were made of Resident #25: On 7/6/21 at approximately 11:30 a.m., Resident	F 550		

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F 550	Continued From page 3 #25 was in bed and it was obvious she did not have use of her right arm and right leg. The assigned Certified Nursing Assistant (CNA) #3 stated she had just finished AM care. The resident wore a hospital/facility gown, a head cap and a right hand splint, and her right leg was in an abducted (spread outward) position elevated on a pillow. She took time to respond when spoken to and if questions were asked of her. She stated in a slow hesitated voice (expressive aphasia), "Excuse my appearance, I have no clothing and my hair is not done." The clothes closet was opened to reveal ample clothing, mostly winter type. Again, in a slow hesitated speech pattern she stated she wanted someone to go to "(Name of a major clothing store)" to purchase lighter weight clothing and bras. When asked if the large suit cases belonged to her near the foot of her bed against the wall she stated, "Yes, those are mine, but I don't want them out because if they go down to the lady to wash, I may never see them again." It was clarified with her that if she were assured her clothes would be safe; she would have someone help her transfer some lighter weight clothing out of her suitcase to her closet. She also said she wanted to wear her own gowns at night and regular clothes during the day. It was obvious that the resident had a lot of long thick hair that was matted, as evident around the resident's nape of her neck. When asked to see her hair, she shook her head from side to side and with her left hand, pulled up the front of the cap, which validated matted hair. She stated she could not remember how long it had been since her hair was washed and she wanted it cut to better manage. The resident remained in a hospital gown the remainder of the day with this surveyor's last observation on 7/6/21 at approximately 5:00 p.m.	F 550		

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F 550	Continued From page 4 On 7/7/21 at approximately 12:15 p.m., the resident was observed in her bed with a hospital/facility issued gown on, same winter type clothes in her closet, cap on her head with the condition of her hair unchanged. The resident stated she did not want to get out of bed without clothes on. The same CNA (#3) from 7/6/21 had provided AM care for the resident. The CNA said she was not told in report that the resident got out of bed or wore regular clothing. She stated it was her second day and she did not know too much about the resident and she did not ask her about whether she wanted to wear any of her personal clothing. The CNA said the resident was mostly non-verbal, but she could nod yes or no. The MDS coordinator was in the resident's room assisting to pass lunch trays. The resident remained in a hospital gown the remainder of the day with this surveyor's last observation on 7/7/21 at approximately 5:00 p.m. The aforementioned concerns were voiced to the Unit Manager Registered Nurse (RN) #2. On 7/8/21 at approximately 12:00 p.m., the aforementioned concerns from the resident was shared with the Administrator. On 7/8/21 at approximately 1:15 p.m., the MDS coordinator and Patient Care Associate (PCA) #2 was in the resident's room. It was asked if they were aware the resident wanted to wear her personal gowns and have some of her existing heavier type clothing changed out to lightweight clothing. PCA #2 opened the closet and asked the resident if she wanted all the clothes on the left side taken out or what did she want to keep. The resident lifted her left hand and tried to speak, as the PCA repeated what she previously	F 550		

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F 550	Continued From page 5 said. She did not give the resident time to express herself in which she was fully capable of doing, but in a slow and deliberate pace. The MDS coordinator then took one item at a time and asked the resident if she wanted to keep in the closet or take out. The resident was able to focus and say, "Yes or No." It was mentioned by both the MDS Coordinator and the PCA that this technique of communicating, allowing the resident to make choices with her clothing had never been explored. On 7/8/21 at approximately 1:30 p.m., the Administrator was in the resident's room following up on the resident concerns that were shared with her from this surveyor. The MDS Coordinator was brought into the room, as well as the assigned Patient Care Associate (PCA) #2. It was demonstrated that the resident was able to select her personal clothing to sort. The Administrator asked to see the resident's hair that was hanging out of the left side of her head cap; the resident flipped up the front and nodded from side to side, "no." The resident told the Administrator she wanted her hair washed and cut, she was okay with someone going through her clothing and trading out the winter clothes for some lighter weight clothing and she did not want to wear only hospital gowns. The Administrator responded that she would work a plan and set up several sessions at a time to sort through her clothing, as well as time to wash and cut the resident's hair. She stated that was evident that the resident could communicate, but the staff needed to be trained to ask the question and give the resident a chance to answer, not to guess what she wants or speak for her. The facility's resident rights document posted	F 550		

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F 550	Continued From page 6 throughout the facility and presented and explained to all residents upon admission identified that every resident had the right to dignity, respect and freedom related to exercising self-determination and treated with consideration, respect and dignity.	F 550		
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.	F 551	**F 551** **1. Resident #25 was assisted with changing seasonal clothing from winter to spring/summer as selected by resident.** **2. Current residents have the potential to be affected by this deficient practice. Audit completed to identify any concerns regarding ability to choose preferred clothing.** **3. Nursing staff educated on providing proper clothing selection depending on preference of resident by Director of Nursing/designee. Current staff educated on resident rights to include selecting clothes to wear by Administrator/designee. Education will be provided to agency staff and new employees during orientation.** **4. Administrator/designee will interview 5 residents weekly for 12 weeks for any concerns with ability to select clothes to wear. Director of Nursing/designee will observe 5 non-interviewable residents weekly for 12 weeks for clothing concerns. Results of audits will be taken to QAPI committee monthly X 3 for review and revision as needed.** 8/9/21	

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F 551	Continued From page 7 §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff and resident interviews, the facility staff failed to honor choices for 1 of 41 residents (Resident #25) in the survey sample and assist to change out seasonal clothing from winter to spring and summer. The findings included:	F 551		

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F 551	Continued From page 8 Resident #25 was admitted to the nursing facility on 3/23/17 with diagnoses that included type II diabetes mellitus, stroke with right sided hemiplegia and hemiparesis and expressive aphasia, high blood pressure and non-Alzheimer's dementia. The resident's most recent Minimum Data Set (MDS) assessment was a quarterly and coded Resident #25 with clear speech, able to understand the staff and was understood by them. She was coded on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15, which indicated she was cognitively intact with the skills needed for daily decision-making. She was coded as having no problems with behavior and mood. The resident required extensive assistance of one staff for bed mobility, dressing, toilet use, bathing and personal hygiene. She was impaired on one side, upper and lower, in range of motion. The wheelchair was her primary mode of transportation. The resident was coded not to reject care. The Significant Change in Status assessment dated 11/11/20 coded the resident as responding "very important" related to choosing what clothes to wear and taking care of her belongings. Quarterly MDS assessments do not code for daily preferences. The care plan dated 3/7/21 or 5/11/21 did not identify choices related to allowing the resident to choose clothing or a plan with goals and interventions to honor her choices, which was very important to her per the last full assessment of 11/11/20.	F 551		

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F 551	Continued From page 9 The last Psychological services visit was dated 6/23/21. One of the concerns related to the provider included, "Pt. presented guarded; with expressions of stress related to her gown being too big." The following observations were made of Resident #25: On 7/6/21 at approximately 11:30 a.m., Resident #25 was in bed and it was obvious she did not have use of her right arm and right leg. The assigned Certified Nursing Assistant (CNA) #3 stated she had just finished AM care. The resident wore a hospital/facility gown. She took time to respond when spoken to and if questions were asked of her. She stated in a slow hesitated voice (expressive aphasia) to excuse her appearance and she had no clothing. The clothes closet was opened to reveal ample clothing, mostly winter type. Again, in a slow hesitated speech pattern she stated she wanted someone to go to "(Name of a major clothing store)" to purchase lighter weight clothing and bras. When asked if the large suit cases belonged to her near the foot of her bed against the wall she stated, "Yes, those are mine, but I don't want them out because if they go down to the lady to wash, I may never see them again." It was clarified with her that if she were assured her clothes would be safe; she would have someone help her transfer some lighter weight clothing out of her suitcase to her closet. She also said she wanted to wear her own gowns at night and regular clothes during the day. The resident remained in a hospital gown the remainder of the day with this surveyor's last	F 551		

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F 551	Continued From page 10 observation on 7/6/21 at approximately 5:00 p.m. On 7/7/21 at approximately 12:15 p.m., the resident was observed in her bed with a hospital/facility issued gown on and the same winter type clothes in her closet. The resident stated she did not want to get out of bed without clothes on. The same CNA (#3) from 7/6/21 had provided AM care for the resident. The CNA said she was not told in report that the resident got out of bed or wore regular clothing. She stated it was her second day and she did not know too much about the resident and she did not ask her about whether she wanted to wear any of her personal clothing. The CNA said the resident was mostly non-verbal, but she could nod yes or no. The MDS coordinator was in the resident's room assisting to pass lunch trays. The resident remained in a hospital gown the remainder of the day with this surveyor's last observation on 7/7/21 at approximately 5:00 p.m. The aforementioned concerns were voiced to the Unit Manager Registered Nurse (RN) #2. On 7/8/21 at approximately 12:00 p.m., the aforementioned concerns from the resident was shared with the Administrator. On 7/8/21 at approximately 1:15 p.m., the MDS coordinator and Patient Care Associate (PCA) #2 was in the resident's room. It was asked if they were aware the resident wanted to wear her personal gowns and have some of her existing heavier type clothing changed out to lightweight clothing. PCA #2 opened the closet and asked the resident if she wanted all the clothes on the left side taken out or what did she want to keep. The resident lifted her left hand and tried to speak, as the PCA repeated what she previously	F 551		

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F 551	Continued From page 11 said. She did not give the resident time to express herself in which she was fully capable of doing, but in a slow and deliberate pace. The MDS coordinator then took one item at a time and asked the resident if she wanted to keep in the closet or take out. The resident was able to focus and say, "Yes or No." It was mentioned by both the MDS Coordinator and the PCA that this technique of communicating, allowing the resident to make choices with her clothing had never been explored. On 7/8/21 at approximately 1:30 p.m., the Administrator was in the resident's room following up on the resident concerns that were shared with her from this surveyor. The MDS Coordinator was brought into the room, as well as the assigned Patient Care Associate (PCA) #2. It was demonstrated that the resident was able to select her personal clothing to sort through. The resident told the Administrator it was okay with someone going through her clothing and trading out the winter clothes for some lighter weight clothing and she did not want to wear only hospital gowns. The Administrator responded that she would work a plan and set up several sessions at a time to sort through her clothing, and make sure they were labeled in order to secure them. She stated that was evident that the resident could communicate, but the staff needed to be trained to ask the question and give the resident a chance to answer, not to guess what she wants or speak for her. The facility's resident rights document posted throughout the facility and presented and explained to all residents upon admission identified that every resident had the right to be treated with consideration, respect, and freedom	F 551		

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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 551	Continued From page 12 to exercise self-determination and that their possessions were secure. The facility's AM care policy, revised 6/15/20, indicated that residents would be dressed appropriate to the time of day, season of the year and activity.	F 551		
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 and staff interviews and clinical record review the facility staff failed to provide the accommodation needed for 1 of 41 residents (Resident #69) in the survey sample. The findings included: The facility staff to ensure Resident #24's call bell remained within reach. Resident #24 was admitted to the nursing facility on 05/11/21. Diagnosis for Resident #24 included but not limited Cerebral Infarction with hemiplegia (paralysis on one side of the body). The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 04/24/19 coded Resident #69 with a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #69 total dependence of two with bathing, extensive assistance of two with bed	F 558	**F 558** **1. Resident #69 had call bell placed within reach 7/7/2021. (resident no longer in facility)** **2. Current residents have the potential to be affected by this deficient practice. An audit was completed to ensure call bells are accessible and any areas of concern addressed.** **3. Facility staff educated on ensuring call bells are accessible and functioning for the residents by Director of Nursing/designee. Education will be provided to agency and new employees during orientation.** **4. Administrator/designee will complete observations of 10 residents weekly for 12 weeks to ensure call bells are accessible. Results of audit will be taken to QAPI committee meeting monthly X 3 for review and revision as needed.** 8/9/21	

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F 558	Continued From page 13 mobility, dressing, toilet use and personal hygiene with Activities of Daily Living care. Resident #69's comprehensive care plan documented Resident #69 ask risk for falls, requires assist with transfers and have above left knee amputation. The goal set by the staff: minimize risks for falls/minimize injuries related to falls. Some of the approaches to manage goal is to implement preventative fall interventions/devices and maintain call light within reach. Educate resident to use call light. During the initial tour on 06/15/21 at approximately 12:00 p.m., Resident #24 was observed lying in bed. Resident observed with severe contracture to his left hand. Resident #69's pancake call bell was located on the floor underneath his bed. On the same day at approximately 2:30 p.m., and 4:15 p.m., Resident #24's pancake call light remains on the floor underneath his bed. On 07/07/21 at approximately 9:15 a.m., Resident #24's pancake call light remains on the floor underneath his bed (same location on 07/07/21). Resident #24 stated, "I have not had my call bell in a couple of days now." LPN #8 went into Resident #24's room along with surveyor. The LPN removed Resident #24's call light off the floor, placed it across without attaching. When asked, "What is the purpose for keeping Resident #2's call light within reach and attached, The LPN replied, "If the resident need something he can call to call for assistance". A pre-exit conference was conducted with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/09/21 at	F 558		

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F 558	Continued From page 14 approximately 2:40 p.m. The facility did not present any further information about the findings. The facility titled: Resident Communication System and Call Light policy with a revision date of 06/30/17. Policy: It is the policy of the facility to provide residents with a means of communicating with staff. A call light is installed in each resident room and toilet/bath areas. The facility responds to resident needs and requests. Answering call lights - General Guidelines: 5. When the resident is in bed or confined to a chair, be sure the call light is within easy reach.	F 558		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and	F 563	**F 563** **1. Resident #73 no longer resides in facility.** **2. Residents with a change in condition or decline have the potential to not receive compassionate care visit. Review of clinical record for last 48 hours for any change of condition or decline for concerns regarding visitation.** **3. Interdisciplinary team has been educated on compassionate care visits by Director of Nursing/designee. Education will be provided to agency staff and new employees during orientation.** **4. Director of Nursing/designee will audit and review residents with change in condition/decline to determine the need for compassion care visits weekly for 12 weeks. Results of audits taken to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of compliance- 8/9/21**	

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F 563	Continued From page 15 (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview and in the course of a complaint investigation, it was determined that facility staff failed to allow compassionate care visits for one resident of 41 residents in the survey sample; Resident #73. The findings included: Resident #73 was admitted to the facility on 11/18/16 with diagnoses that included but were not limited to heart failure, Alzheimer's disease, high blood pressure and age related osteoporosis. Resident #73's most recent comprehensive MDS (Minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/5/20. Resident #73 was coded as being severely impaired in cognitive function scoring 06 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Review of Resident #73's clinical record revealed that she had been sent out to the hospital on 10/12/20 for lethargy and the inability to eat. Resident #73 arrived back to the facility with the following diagnosis: "Alzheimer's Dementia with behavioral disturbance: Stepwise deterioration..."	F 563		

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F 563	Continued From page 16 Resident #73 arrived back to the facility on 10/15/20 with a continued decline in appetite. The following note was documented by the physician on 10/26/20: "...Dementia is unchanged. Poor appetite is unchanged as far as solids she is drinking slightly more fluids...Spoke at length with daughter today...if she continues to not eat the daughter would speak with hospice." Review of a physician note dated 10/28/20 revealed that the daughter was allowed to visit once on 10/28/20 to make a determination if she wanted to place her mom on hospice. The following was documented in part: "Anorexia daughter was allowed in to see patient even she could only get her to drink some water. Patient seemed enthusiastic but then would stop after a certain amount and would not eat much food. No feeding tubes just encouragement. Failure to thrive: She is dwindling quickly with no oral intake many discussions had over the phone with the daughter this is the first time I met her in person. - Advanced Directive: We went over a new post form. The daughter has agreed to principal to no more labs or IVs ER visits or hospitalizations. She is already DNR...Dementia is unchanged..." Review of Resident #73's October POS (Physician Order Summary) revealed an order for Hospice Services starting on 10/29/20. A note from the physician dated 11/9/20 documented in part, the following: "...When I examine her she is unable to talk it (sic) all hardly...It's getting drier by the day because memories (sic) are not moist at all anymore...currently in (sic) hospice dehydrated not eating or drinking...less responsive nonverbal today..."	F 563		

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F 563	Continued From page 17 There was no evidence that the facility staff alerted the daughter to see her mom before passing on 11/10/20. The following note was written on 11/10/20 at 2:12 p.m.: "Responded to LPN (licensed practical nurse) reports of resident without pulse or respiration. This RN noted no audible heart rate or respiration after one full minute and pronounces TOD (Time of Death) at 2:05 p.m. Called placed to (Name of hospice provider) -reports hospice nurse not readily available to report to facility at this time but willing to notify daughter, inquire if visit is warranted, and confirm funeral home arrangements. Pending return call from hospice. The next note dated 11/10/20 at 5:18 p.m. documented the following: "Family completed visit with resident. (Name of Crematorium) notified at this time per family request." On 7/8/21 at 9:15 a.m., an interview was conducted with OSM (Other Staff Member) #3, Social Services. OSM #3 stated that visitation was not allowed during November 2020 timeframe; however compassion care visits were allowed if the resident was on the "verge of death." OSM #3 denied having conversation with Resident #73's daughter regarding compassion care visits. On 7/8/21 at 12:50 p.m., an interview was attempted with a nurse who frequently worked with Resident #73 during November of 2020. She could not be reached for an interview. On 7/8/21 at 1:30 p.m., an interview was	F 563		

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F 563	Continued From page 18 attempted with OSM #5, a former social worker. OSM #5 could recall the daughter wanting to visit her mom and the facility declining her request. OSM #5 stated that the hospice provider would state that the resident was dying and that the daughter needed to be alerted so she could see her mom before that had happened. OSM #5 stated that administration felt that Resident #73 was not actively dying and wouldn't allow visitation until Resident #73 was showing signs of actively dying. OSM #5 stated it was a back and forth thing between the hospice provider and the facility administration. OSM #5 stated that unfortunately the resident did not give the facility signs that she was on her last breath and ended up passing before her daughter could visit. On 7/8/21 at approximately 1:45 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). The DON confirmed that Resident #73 had to show active signs of imminent death in order for family to visit. When asked if she could present her visitation policy related to COVID around that time 11/2020; ASM #2 stated that she wasn't able to present the policy due to the policy being constantly updated and revised. ASM #2 did not have a copy of the policy in November. ASM #2 stated that the hospice nurse did keep telling the daughter that she should be able to visit but that it wasn't hospice's decision. ASM #2 stated that Resident #73 passed before she was presenting any active symptoms of dying such as shortness of breath. When asked if there was any COVID positive residents in the building at that time; ASM #2 stated that she didn't think so but that she thought around that time there was a high level county positivity rate. ASM #2 was asked to provide that	F 563		

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F 563	Continued From page 19 information. Hospice notes were also requested for Resident #73. On 7/8/21 at 2:35 p.m., an interview was conducted with Resident #73's daughter. Resident #73 stated that after her mother was placed on hospice services, she had several conversations with the social worker and the DON (Director of Nursing) regarding being able to visit her mom. The daughter stated that she was told on several occasions that her mom had to be on her "last breath" in order to come into the facility. The daughter stated that she was under the impression that compassion care visits were allowed and that her mom had declined quickly after readmission into the facility; that she should have been able to see her mom. The daughter stated she was allowed one visit so she could determine if she thought her mother needed hospice services. The daughter stated that she wore all the protective gear including an N95. The daughter was not sure why she could visit then and not when her mother continued to decline. The daughter stated that her mother died alone with no family around. On 7/8/21 at 2:45 p.m., and 3:15 p.m., the hospice nurse was attempted for an interview. She could not be reached. On 7/8/21 at approximately 4:00 p.m., ASM #1 presented the county level positivity rate that was 7.2 percent on 11/10/20 and her line list of COVID positive residents for December of 2020. There was no COVID positive residents during the time of 11/10/20. ASM #1 could not provide hospice notes from the hospice provider. Review of the visitation policy that was in place on	F 563		

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F 563	Continued From page 20 4/15/20 that was reviewed on a COVID 3-5 day on survey conducted 10/26/20 documented in part, the following: "Visitors who need to enter the building for end of life care situations are evaluated on a case by case basis to ensure safety for all. Visitors who are permitted to enter the building for end of life situations are screened for fever and respiratory symptoms. They are also required to frequently clean their hands, limit their visit to a designated area within the building and wear a facemask." Review of the CMS (Centers for Medicare and Medicare Services) QSO (Quality/Quality, Safety & Oversight Group) letter dated 9/17/2020 documented the following guidance regarding visitation for end of life situations. The following in part, was documented: "While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to: · A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support. ·A resident who is grieving after a friend or family member recently passed away. ·A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration. ·A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the Past). Allowing a visit in these situations would be	F 563		

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F 563	Continued From page 21 consistent with the intent of, "compassionate care situations." Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident's needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. Compassionate care visits, and visits required under federal disability rights law, should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak.	F 563		
F 578 SS=E	Complaint deficiency Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578	**F 578** **1. Resident #63, #9, #32 have had advanced directives process has been reviewed with resident/responsible party. Care plans and orders are updated to reflect resident choice. Resident #27, #22 no longer reside in facility.** **2. Audit of current residents he potential to be affected by the same deficient practice. Areas of concern addressed.** **3. Licensed nurses educated on the advanced directive process by administrator/designee. Education will be provided to agency and new employees during orientation.** **4. Director of Nursing/designee will audit new admits and resident with a change of condition weekly for 12 weeks for advanced directives in place to include correct order and accurate care plan.** See other pg	

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F 578	Continued From page 22 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to ensure 1 of 41 residents (Resident #63) had an accurate medical record for an advanced directive and failed to ensure 4 out of 41 residents (Resident #27, Resident #22, Resident #9 and Resident #32) in the survey sample were given the opportunity to formulate an advance directive. The findings included: 1. The facility staff failed to ensure Resident #63 had an accurate medical record for an advanced directive. Resident #63 was originally admitted to the nursing facility on 03/11/21. Diagnosis for Resident #63 included but not limited to Acute Upper Respiratory Infection. Resident #63's	F 578	**Results of audits to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of Compliance:** 8/9/21	

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F 578	Continued From page 23 Minimum Data Set (MDS-an assessment protocol) a significant change assessment with an Assessment Reference Date (ARD) of 06/15/21 coded Resident #63 a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no impaired cognitive skills for daily decision-making. Resident #63's person centered care plan dated 03/03/21 had a focus which read; Resident #63 as chosen Do Not Resuscitate Comfort Care (DNRCC). The goal read; code status wish will be honored daily. Some of the interventions included; if resident/responsible party chosen to change code status, necessary protocol will be completed as evidence by new order, update documentation/care plan and review code status annually, quarterly and as needed. Review of Resident #63's Order Summary Report for July 2021 revealed the following order: "Full Code" which means if person's heart stop beating and/or they stopped breathing, all resuscitation procedures will be provided to keep them alive. The review of Resident #63's clinical record revealed the following document "Durable Do Not Resuscitate" (DDNR) order. An interview was conducted with the Unit Manager on 07/08/21 at approximately 9:36 a.m. She reviewed Resident's #63 current physician orders and stated, "Resident #63 is a Full Code." When asked, "What will happen if Resident #63 stop breathing" she replied, "Cardiopulmonary resuscitation (CRP) would be initiated because her binder reads (Full Code). The Unit Manager was asked to review Resident #63's Advance Directive. After she reviewed Resident #63's Advance Directive, she replied, 'Resident #63 has	F 578		

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F 578	Continued From page 24 a signed DNR form so, CRP should not have been initiated." The Administrator, Director of Nursing and Regional Director of Operations were informed of finding during a pre-exist meeting on 07/08/21 at approximately 2:40 p.m. The facility staff did not present any further information about the findings. 2. The facility staff failed to execute the opportunity to provide an advance directive for Resident #9. 3. The facility staff failed to execute the opportunity to provide an advance directive for Resident #22. 4. The facility staff failed to execute the opportunity to provide an advance directive for Resident #27. 5. The facility staff failed to execute the opportunity to provide an advance directive for Resident #32. The findings include: 2. Resident #9 was admitted to the facility on 4/15/20 and readmitted to the facility on 5/20/21. The current diagnoses included; Essential Hypertension and Chronic Respiratory Failure with Hypoxia. The current Minimum Data Set (MDS) a Quarterly Assessment with an Assessment Reference Date (ARD) of 4/14/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #9 cognitive abilities for daily decision making were intact.	F 578		

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F 578	Continued From page 25 A review of the clinical record on 7/07/21 revealed there were no advance directives in the clinical record on the above residents. 3. Resident #22 was admitted to the facility on 2/24/21 and has never been discharged. The current diagnoses included; Dementia with Unspecified Behavioral Disturbance and Cognitive Communication Deficit. A review of the clinical record on 7/07/21 revealed there were no advance directives in the clinical record on the above residents. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/02/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring a 3. This indicated Resident #22 cognitive abilities for daily decision making were severely impaired. 4. Resident #27 was admitted to the facility on 3/25/21 and readmitted to the facility on 4/05/21. The current diagnoses included; Essential Hypertension and Arthritis Due To Other Bacteria, Right Knee. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 05/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #27 cognitive abilities for daily decision making were intact. A review of the clinical record on 7/07/21 revealed there were no advance directives in the clinical record on the above residents.	F 578		

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F 578	Continued From page 26 5. Resident #32 was admitted to the facility on 1/15/20 and never discharged. The current diagnoses included; Chronic Respiratory Failure and Unspecified Dementia without Behavioral Disturbance. The Annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 05/13/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #32 cognitive abilities for daily decision making were intact. A review of the clinical record on 7/07/21 revealed there were no advance directives in the clinical record for the above residents. During an interview with the Unit Manager (Registered Nurse/RN) #2 on 07/07/21 at approximately 4:42 p.m., concerning the above Resident's Advanced Directives she stated, "I don't see any advance directives." They should have had an advance directive." Policy: Titled: "Your Path" Advance Care Planning Meeting Protocol. Effective Date: 5/01/14. Date Revised: 09/01/15. Purpose: It is the policy of this facility to ensure "Your Path" - Advance Care Planning" is conducted upon each patient's admission to the facility. The "Your Path-Advance Care Planning" meeting will be completed within 5 days of admission prior to completing and or/updating the plan of care. Procedure: 1. Admission care planning conferences will be available with each resident and family member(s) upon admission to the facility. 2. The Your Path team consisting of Administrator, DON/Unit Manager, BOM (Business Office	F 578		

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F 578	Continued From page 27 Manager), MDS/Case Manager, SW (Social Worker) will meet with the resident and family members within a reasonable timeframe (3-5 days) for an Your Path meeting to discuss pertinent information regarding the patient's wishes. 3. Upon Admission, the patient, family and/or responsible party will be informed of the times for the Your Path meeting. (Please utilize Your Path meeting notification postcard). 4. During the Your Path, the resident's end of life wishes will be discussed with a healthcare professional. On 7/08/21 at approximately 4:19 pm an interview was conducted with the Administrator, the DON (Director of Nursing) and with the Corporate Clinical Nurse concerning the above issues. No comments were voiced at this time.	F 578		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the 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	F 622	**F 622** **1. Resident #27 no longer resides in facility.** **2. Residents transferred to the hospital have the potential to be affected by this deficient practice. Audit of resident hospital transfers since 7/1/2021 for completion of transfer process for any trends and patterns.** **3. Licensed nursing staff educated on hospital transfer/discharge process by Director of Nursing/designee. Education will be provided to agency and new licensed nurses during orientation.** **4. Director of Nursing/designee will audit transfer/discharges to hospital 5 times a week for 12 week s for compliance with hospital transfer/discharge process.** →	

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F 622	Continued From page 28 otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified 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.	F 622	**Results of audit will be taken to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of Compliance:**	8/9/21

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F 622	Continued From page 29 (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's Care Plan to include their goals after being transferred and admitted to the hospital for one resident (Resident #27) in a survey sample of 41 residents. The findings included:	F 622		

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F 622	Continued From page 30 Resident #27 was admitted to the facility on 3/25/21 and readmitted to the facility on 4/05/21. The current diagnoses included; Essential Hypertension and Arthritis Due To Other Bacteria, Right Knee. The quarterly, Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 05/11/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #27 cognitive abilities for daily decision making were intact. A review of the clinical record on 7/07/21 revealed there were no advance directives in the clinical record on the above residents. A nursing note dated 3/30/2021(6:44 PM) Reads: Resident sent to ER this morning for n/v (Nausea/Vomiting). A nursing note dated 4/03/21 revealed that Resident #27 was sent to the ER (Emergency Room) via stretcher. The Discharge MDS assessments was dated for 03/30/21 - discharged with return anticipated. On 07/08/21 at approximately 11:24 AM an interview was conducted with RN (Registered Nurse) #2 concerning Resident #27's admissions documents and Care Plan Summary sent to the local hospital. She stated, "If it's not in the chart, they didn't do it." On 07/08/21 at approximately, 2:50 PM an interview was conducted with LPN (Licensed Practical Nurse) #6 concerning hospital	F 622		

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F 622	Continued From page 31 admissions packets to include the Care Plan summary sent from the nursing facility when a resident is admitted to the hospital. He stated, "We arrange for transport, find out if resident is DNR (Do Not Resuscitate),print the bed hold policy, face sheet, demographics, doctor's orders, treatments and the Care Plan. We document in the chart, contact family, notify the doctor. We then put the documents in envelope to hand to transport and call the nurse at the hospital where resident is being sent and give the report. On 7/08/21 at approximately 4:19 PM an interview was conducted with the Administrator, the DON (Director of Nursing) and with the Corporate Clinical Nurse concerning the above issues. No comments were voiced at this time.	F 622		
F 657 SS=D	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	F 657	**F 657** **1. Resident #35 has received a care plan invitation for care plan meeting scheduled on 8/18/2021** **2. Current residents have the potential to be affected by this deficient practice. An audit of scheduled care plan meetings since 7/1/2021 for any concerns regarding invitation.** **3. MDS nurse and social service director educated on ensuring each resident and responsible party receive invitation to their scheduled care plan meeting by DON/designee. Any agency or new staff hired for MDS or social service department will be educated upon hire.** **4. Administrator/designee will audit weekly for 12 weeks residents scheduled for care plan meetings to ensure residents/responsible parties have been invited to attend. Results of audits will be taken to QAPI committee monthly x 3 for review and revision as needed.** **5. Date of compliance:** 8/9/21	

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F 657	Continued From page 32 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 resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide evidence that one out of 41 residents was invited to attend a care plan meeting, Resident #35. The findings included: Resident #35 was admitted to the facility on 12/9/20 and readmitted on 2/16/21 with diagnoses that included but were not limited to chronic heart failure, spinal stenosis, and chronic embolism and thrombosis of unspecified deep veins of lower extremity (bilateral). Resident #35's most recent MDS (Minimum Data Set Assessment) was a quarterly assessment with an ARD (assessment reference date) of 5/20/21. Resident #35 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status exam). On 7/6/21 at 3:32 p.m., an interview was conducted with Resident #35. He could not recall receiving a recent invitation for a care plan meeting. Resident #35 stated that it had been awhile.	F 657		

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F 657	Continued From page 33 Review of Resident #35's clinical record revealed care plan invitations for 12/23/20 and 3/3/21. There was no evidence that Resident #35 had been recently invited to attend a care plan meeting or that a recent care plan meeting had been held. On 7/8/21 at 9:17 a.m., an interview was conducted with OSM (Other Staff Member) #3, Social Services. When asked if residents were invited to their own care plan meetings; OSM #3 stated, "Yes." When asked how often care plan meetings were held; OSM #3 stated that care plan meetings were held every 90-92 days unless there was a significant change. OSM #3 stated that if a resident is alert and oriented; it would be appropriate for them to attend their own care plan meeting. When asked when invitations were sent out; OSM #3 stated, "A couple of days prior to the meeting." This writer showed OSM #3 that Resident #35's last care plan meeting was held on 3/3/21. When asked if she had evidence that another care plan meeting had been held; OSM #3 stated that Resident #35 had a meeting scheduled in August 2021 but that she would check to see if one was done in-between then. OSM #3 stated that a care plan meeting should have been done around June time frame. On 7/8/21 at 9:50 a.m., OSM #3 could not find any evidence that a care plan meeting was held in June of 2021. OSM #3 stated she couldn't figure out why one was not held. On 7/8/21 at 4:07 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), and ASM #3 the corporate nurse were made aware of the above concerns.	F 657		

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F 657	Continued From page 34 No further information was presented prior to exit. Facility policy titled, "Comprehensive Care Planning," documented in part, the following: "J) Resident scheduled for the Resident Care conference include: 1) New admissions who are MDS was completed within the previous 7 days. 2) Residents who have returned from the hospital in the past week. Their previous MDS and Care Plan must be reviewed and updated. 3. Residents who have had 90-day review assessments or an annual full assessment completed within the previous 7 days. A facility designee is responsible for preparing and updating a list of those residents scheduled for each conference. The list is generated ten (10) days prior to each meeting. Copies of this list are distributed to each Department Head Discipline, each Nursing Unit, each Rehabilitation Service and the Resident Care Plan Coordinator. Revisions to the distributed list are made daily. The facility designee is responsible for delivering to each resident who is scheduled for conference an invitation to attend the meeting. The letter of requested participation (Original) is presented to the resident at least (5) days prior to the conference date. A designated time of meeting is given to each resident...A copy of the letter is maintained for reference."	F 657		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of	F 676		

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F 676	Continued From page 35 daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, a complaint investigation, resident and staff interview and review of facility documentation, the facility staff failed to ensure 2 of 41 residents (Resident #25 and #49) were able to continue to maintain their ability to independently perform mouth care.	F 676	**F 676** **1. Resident #23 had electric toothbrush repaired; resident #49 had toothbrush and toothpaste placed in room for use during survey.** **2. Current residents have potential to be affected by this deficient practice. Audit of current residents for oral care supplies available and being utilized.** **3. Nursing staff have been educated on maintaining residents independent with completing ADL tasks to include oral hygiene, and providing assistance to all residents as needed by Director of Nursing/designee. Agency and new hires will be educated during orientation.** **4. Director of Nursing/designee will audit 5 residents weekly for 12 weeks to ensure oral care supplies and in place and that oral care is performed. Results of audits will be taken to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of compliance:**	8/1/21

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F 676	Continued From page 36 The findings included: 1. The facility staff failed to provide Resident #25 her electric toothbrush that she independently uses to maintain good oral hygiene. Resident #25 was admitted to the nursing facility on 3/23/17 with diagnoses that included type II diabetes mellitus, stroke with right sided hemiplegia and hemiparesis and expressive aphasia, high blood pressure and non-Alzheimer's dementia. The resident's most recent Minimum Data Set (MDS) assessment was a quarterly and coded Resident #25 with clear speech, able to understand the staff and was understood by them. She was coded on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15, which indicated she was cognitively intact with the skills needed for daily decision-making. She was coded as having no problems with behavior and mood. The resident required extensive assistance of one staff for bed mobility, dressing, toilet use, bathing and personal hygiene. She was impaired on one side, upper and lower, in range of motion. The wheelchair was her primary mode of transportation. The resident was coded not to reject care. The care plan dated 5/11/21 identified that the resident had a self-care deficit and the goal set by the staff for the resident was that her needs would be met. Some of the interventions the staff would implement to accomplish this goal included assist with oral care and to promote independence, providing positive re-enforcement	F 676		

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	495392	A. BUILDING _____ B. WING _____	C 07/08/2021

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F 676	Continued From page 37 for all activities attempted. The following observations were made of Resident #25: On 7/6/21 at approximately 11:30 a.m., Resident #25 was in bed and it was obvious she did not have use of her right arm and right leg. The assigned Certified Nursing Assistant (CNA) #3 stated she had just finished AM care. The resident had a right hand splint in place. The resident stated she was not able to use her right hand, which was her dominant hand, but could use her battery-operated toothbrush with her left hand. She stated, "I brush my teeth better when I do it myself with that (pointed to the electric toothbrush). I just need a new brush head. They said no I could not use it and had to use that one (pointed to the manual toothbrush in the package on top of her over bed table)." The resident's teeth were covered with plaque and what appeared to be food particle residue. Resident #25 was not quick to respond and spoke with slow deliberate speech. She could not be rushed during conversation, which was important in order to ascertain her needs. On 7/7/21 at approximately 12:15 p.m., the resident was observed in her bed and stated she had to use the same manual toothbrush. Her teeth remained unchanged and in need of further adequate brushing. This surveyor asked the resident if the nursing staff checked her teeth after they remove the basin and cup, she responded, "No, I want the other toothbrush." On 7/7/21 at 5:00 p.m., the aforementioned issue was brought the attention of the Unit Manager, Registered Nurse (RN) #2.	F 676		

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F 676	Continued From page 38 On 7/8/21 at approximately 1:15 p.m., Patient Care Associate (PCA) #2 was in the resident's room. She stated she gave the resident a cup of water along with a toothbrush, sat the small basin on the resident's over bed table and the resident brushed her own teeth with a regular toothbrush. On 7/8/21 at approximately 1:30 p.m., the Administrator was in the resident's room following up on the resident concerns that were shared with her from this surveyor. The Administrator was shown the resident's battery operated toothbrush and told that the resident stated she could brush her teeth more effectively with the battery operated toothbrush, but would needed a new brush head that no one would obtain for her. The Administrator looked at the toothbrush and said, "This is a pretty inexpensive one, I can go out and get that one without a problem." The Administrator stated that it was evident that the resident could communicate, but the staff needed to be trained to ask the question and give the resident a chance to answer, not to guess what she wants or speak for her. 2. The facility staff failed to provide Resident #49 with a toothbrush who was able to independently use to maintain good oral hygiene. Resident #49 was admitted to the nursing facility on 8/1/19 with diagnoses that included incomplete paraplegia, bipolar disorder, type 2 diabetes mellitus, restless leg syndrome and age related osteoporosis. The most recent Minimum Data Set (MDS) assessment was a quarterly dated 4/6/21 and coded the resident on the Brief Interview for	F 676		

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F 676	Continued From page 39 Mental Status (BIMS) with a score of 11 out of a possible score of 15, which indicated she was moderately impaired in the skills for daily decision-making. Resident #49 was assessed to require extensive assistance from one staff for personal hygiene. The resident was coded to not reject care. The care plan dated 4/3/21 identified Resident #49 had an ADL self-care performance deficit. The goal set by the staff for the resident was that she would maintain current level of function through the next review date. The interventions the staff would implement to accomplish this goal included that the resident was able to perform personal/oral care with set-up assistance. On 7/6/21 at 12:02 p.m., Resident #49 was being transferred from bed to wheelchair via a sit-to-stand mechanical lift by two CNAs, #3 and #4. After the resident was transferred to the wheelchair and pushed up to the sink, she stated in the presence of her assigned CNA #3 that she had not brushed her teeth in a couple of days and felt like eggs were stuck in her teeth, "especially the bottom." The resident showed the CNA and this surveyor the condition of her teeth, which revealed thick adhered yellow substance across all of her teeth, especially on the bottom teeth. She stated that her basin, toothbrush and toothpaste was always kept in the medicine cabinet lowest shelf, but when she asked the CNA the previous day (7/5/21) to give her the toothbrush, she was told it was in the basin, but it was not and she was not provided a replacement. The resident opened the cabinet and it was as the resident stated; there was a basin, toothpaste and no toothbrush. The current CNA #3 stated it was her first day in the facility and it was the	F 676		

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F 676	Continued From page 40 resident's lucky day because she was going to immediately get the resident a toothbrush. The resident was independently able to apply toothpaste, brush her teeth and rinse her mouth. The resident smiled to show the CNA and this surveyor her teeth, which were completely absent of the previously observed thick yellow substance. The resident clapped her hands. On 7/7/21 at approximately 5:00 p.m., the aforementioned issue was shared with the Unit Manager Registered Nurse (RN) #2. The facility's policy and procedures dated 1/2011 and last revised on 6/15/20 indicated that morning care would be offered each day to promote resident comfort, cleanliness, grooming and general well-being. Residents who are capable of performing their own personal care are encouraged to do so, but will be provided set up assistance if needed. COMPLAINT DEFICIENCY	F 676		
F 677 SS=E	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, resident and staff interviews and clinical record review the facility staff failed to ensure 3 of 41 residents (Resident #67, Resident #22 and Resident #30) who were unable to carry out activities of daily living (ADL) receives the necessary services to maintain	F 677	**F 677** **1. Resident #25 has received hair care, Residents #67, #22, #30 have received nail care.** **2. Current residents have the potential to be affected by this deficient practice. Audit completed f residents for any resident requiring nail and hair care. Areas of concern addressed.** **3. Nursing staff educated on providing nail and hair care for residents by Director of Nursing/designee. Education will be provided to agency and new nursing staff as part of orientation.** **4. Unit Manager/designee will observe 5 residents weekly for 12 weeks to ensure nail and hair care are provided. Results of audits will be taken to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of compliance:** 9/9/2	

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F 677	Continued From page 41 fingernail care and failed to ensure 1 resident 41 residents (Resident #25) in the survey sample was provide personal grooming that included to wash and cut hair. The findings included: 1. The facility staff failed to ensure that fingernail care was provided to Resident #64. Resident #67 was admitted to the facility on 05/01/21. Diagnosis for Resident #67 included but not limited Cerebral Infarction. Resident #67's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 06/17/21 coded Resident #67 a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive skills for daily decision-making. In addition, the MDS under section G (functional status) coded Resident #67 with activity only occurred once or twice with personal hygiene and activity did not occur with bathing. Resident #67's comprehensive care plan documented Resident #67 total dependence from grooming, bathing and dressing. The goal set by the staff: resident will not show no signs or symptoms of poor hygiene or skin breakdown. One of the approaches to manage goal is to perform personal hygiene routinely and as needed. In addition, the care plan documented Resident #67 has self-care deficit. The goal set by staff: needs will be met and the intervention to manage goal is to assist with activities of daily living, dressing and grooming. During the initial tour on 07/06/21 at approximately 12:25 p.m., Resident #67 was	F 677		

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F 677	Continued From page 42 observed lying in bed with his hands placed outside of the covers. The surveyor observed Resident #67 fingernails were long with brown substance under his fingernails. On the same day at approximately 4:10 p.m., Resident 67's fingernails remained unchanged. On 07/07/21 at approximately 8:55 a.m., Resident #67's fingernails remains unchanged; long with brown substance under his fingernails. An interview was conducted with Resident #67 who stated, "I have asked nursing to cut my fingernails but it never happened." On 07/08/21 at approximately 10:15 a.m., the Unit Manager and this surveyor went into Resident #67's room. The Unit Manager stated, "Yes, his nails need to be cut and trimmed." The Unit Manager spoke with Resident #67's Certified Nursing Assistant (CNA) instructing her to cut and trimmed Resident #67's fingernails. The CNA stated, "I need a pair of nail clippers; the Unit Manager stated, "I will get them for you right now." On the same day at approximately 2:00 p.m., Resident #67's fingernails remains unchanged, long with brown substance under his fingernails. A pre-exit conference was conducted with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/08/21 at approximately 2:40 p.m. The facility did not present any further information about the findings. The findings included:	F 677		

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F 677	Continued From page 43 2. Resident #22 was admitted to the facility on 2/24/21 and has never been discharged. The current diagnoses included; Dementia with Unspecified Behavioral Disturbance and Cognitive Communication Deficit. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/02/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring a 3. This indicated Resident #22 cognitive abilities for daily decision making were severely impaired. In section" G" (Physical functioning) the resident was coded as requiring limited assistance of one person for transfers, walking in the room, corridor and locomotion on the unit. Requiring extensive assistance of one person for dressing, toilet use, personal hygiene and requires supervision set up help with eating. Requires the help of one person physical assistance with bathing. The Care Plan dated 2/24/21 reads: Focus: The resident has an ADL Self-Care Performance Deficit r/t activity intolerance, generalized weakness, cognitive deficits, behavioral patterns. Goal: The resident will maintain current level of function through the next review date. Interventions: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. On 07/07/21 at approximately 4:44 PM an observation of Resident #22 fingernails were made with LPN #6. Fingernails (All 10 fingernails) on both hands had black debris under them. LPN #3 stated, "I will get her CNA to clean her nails."	F 677		

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F 677	Continued From page 44 On 7/07/21 at approximately 5:32 PM an interview was conducted with CNA #7 (CNA assigned to Resident #22 today) concerning Resident #22's fingernails. She stated, "We groom residents on shower days or when they need it. I was off yesterday." On 7/08/21 at approximately 2:40 PM concerning nail care. CNA (Certified Nursing Assistant) #3 she stated, "Nail care is provided to residents during bath time especially if residents' nails are dirty." Requested ADL policy was not received from facility staff. On 7/08/21 at approximately 4:19 PM an interview was conducted with the Administrator, the DON (Director of Nursing) and with the Corporate Clinical Nurse concerning the above issues. No comments were voiced at this time. 3. Resident #30 was admitted to the facility on 7/3/17 with diagnoses that included but were not limited to heart failure, peripheral vascular disease, neurogenic bladder, dementia without behavioral disturbance and quadriplegia. Resident #30's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/18/21. Resident #30 was coded as being moderately impaired in cognitive function, scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #30 was coded as requiring extensive assistance from one staff member with personal hygiene and bathing. Resident #30 was coded as having impairments	F 677		

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F 677	Continued From page 45 that affected ROM (Range of Motion) to his bilateral upper extremities. Resident #30's ADL (Activity of Daily Living) care plan dated 12/30/21 documented the following: "(Name of Resident #30 requires extensive assistance with dressing and total assistance from staff with bathing and hygiene... (Name of Resident #30) will be assisted with bathing, dressing, and personal hygiene over the next review period... (Name of Resident #30) will be provided bathing, dressing, and personal hygiene tasks by staff." On 7/6/21 at 2:50 p.m., during an interview with Resident #30, his nails were observed. Resident #30's nails were long approximately 1/2 inch long with black debris underneath each nail. Resident #30 stated that staff did not help him clean his hands after meals or offer to cut his nails. Resident #30 stated that he wanted his nails cut and that he didn't have the hand strength to cut his nails himself. Resident #30 stated that staff have only recently handed him a nail clipper. On 7/7/21 at 9:05 a.m. and 11:10 a.m., Resident #30's nails were in the same condition as they were on 7/6/21; approximately 1/2 inch long with food debris underneath each nail. On 7/7/21 at 1:00 p.m., Resident #30 was finally washed up for the day. Bathing was observed with CNA (Certified Nursing Assistant) #3 on Resident #30. Resident #30 stated to his nursing aide that his finger nails were dirty. CNA #3 stated that she noticed that yesterday and will clean up his hands as well cut his nails. On 7/7/21 at 6:00 p.m., another observation was	F 677		

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F 677	Continued From page 46 made of Resident #30. His nails were trimmed and clean. On 7/8/21 at 8:53 a.m., an interview was conducted with CNA #3, Resident #30's CNA. When asked what was usually observed during bathing/ADL care; CNA #3 stated that she will the resident's check skin, nails etc. CNA #3 stated that she will wash hands real good and clip nails that need to be trimmed. When asked if she was assigned to Resident #30 on Tuesday 7/6/21, CNA #3 stated that she was. When asked if Resident #30's nails were long and debris underneath them on 7/6/21, CNA #3 stated, "Yes, his nails were dirty then." When asked why she did not address his nails on Tuesday, CNA #3 stated that nail clippers were not in the utility room at that time and that Resident #30 did not have nail clippers in his room. CNA #3 also stated that she did not have access to the central supply closet which is kept locked. CNA #3 stated that she did wash Resident #30's hands on Tuesday, but that she couldn't get the debris out of his nails. CNA #3 stated that she did not ask central supply to get her nail clippers. On 7/8/21 at 4:07 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), and ASM #3 the corporate nurse were made aware of the above concerns. Facility policy titled, "Morning Care/AM Care," documented in part, the following: "Morning Care will be offered each day to promote resident comfort, cleanliness, grooming, and general well-being. Residents who are capable of performing their own personal care are encouraged to do so but will be provided with setup assistance if needed. Procedure...provide	F 677		

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F 677	Continued From page 47 fingernail care..." No further information was presented prior to exit. 4. The facility staff failed to provide personal hygiene for Resident #25 who was dependent on the staff to wash her hair. Resident #25 was admitted to the nursing facility on 3/23/17 with diagnoses that included type II diabetes mellitus, stroke with right sided hemiplegia and hemiparesis and expressive aphasia, high blood pressure and non-Alzheimer's dementia. The resident's most recent Minimum Data Set (MDS) assessment was a quarterly and coded Resident #25 with clear speech, able to understand the staff and was understood by them. She was coded on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15, which indicated she was cognitively intact with the skills needed for daily decision-making. She was coded as having no problems with behavior and mood. The resident required extensive assistance of one staff for personal hygiene. She was impaired on one side,	F 677		

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F 677	Continued From page 48 upper and lower, in range of motion. The wheelchair was her primary mode of transportation. The resident was coded not to reject care. The care plan dated 5/11/21 identified that the resident had a self-care deficit and the goal set by the staff for the resident was that her needs would be met. Some of the interventions the staff would implement to accomplish this goal included assist with daily grooming. The following observations were made of Resident #25: On 7/6/21 at approximately 11:30 a.m., Resident #25 was in bed and it was obvious she did not have use of her right arm and right leg. The assigned Certified Nursing Assistant (CNA) #3 stated she had just finished AM care. The resident wore a head cap and a right hand splint, and her right leg was in an abducted (spread outward) position elevated on a pillow. She took time to respond when spoken to and if questions were asked of her. She stated in a slow hesitated voice (expressive aphasia) to excuse her appearance because her hair was not done. It was obvious that the resident had a lot of long thick hair that was matted, as evident around the resident's nape of her neck. When asked to see her hair, she shook her head from side to side and with her left hand, pulled up the front of the cap, which validated matted hair. She stated she could not remember how long it had been since her hair was washed and she wanted it cut to manage it better. On 7/7/21 at approximately 12:15 p.m., the resident was observed in her bed with the same	F 677		

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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 677	Continued From page 49 cap on her head with the condition of her hair unchanged. The same CNA (#3) from 7/6/21 had provided AM care for Resident #25. The CNA said she was not told in report that the resident would have wanted her hair washed even if it was her bath day. She stated it was her second day and she did not know too much about the resident, but could see the resident's hair was matted. The CNA said the resident was mostly non-verbal, but she could nod yes or no. The MDS coordinator was in the resident's room assisting to pass lunch trays. The aforementioned concerns about the resident's hair was voiced to the Unit Manager Registered Nurse (RN) #2. On 7/8/21 at approximately 12:00 p.m., the aforementioned concerns from the resident was shared with the Administrator. On 7/8/21 at approximately 1:15 p.m., the MDS coordinator and Patient Care Associate (PCA) #2 was in the resident's room. The PCA stated she did not ask the resident about the condition of her hair, but would not be able to attempt to wash it without help from another aide or nurse. On 7/8/21 at approximately 1:30 p.m., the Administrator was in the resident's room following up on the resident concerns that were shared with her from this surveyor. The Administrator asked to see the resident's hair that was hanging out of the left side of her head cap; the resident flipped up the front and nodded from side to side, "no." The resident told the Administrator she wanted her hair washed and cut. The Administrator stated she would set up a time to wash and cut the resident's hair. She stated that was evident that the resident could communicate,	F 677		

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F 677	Continued From page 50 but the staff needed to be trained to ask the question and give the resident a chance to answer, not to guess what she wants or speak for her. The facility's policy and procedures dated 1/11 and last revised on 6/15/20 indicated that morning care would be offered each day to promote resident comfort, cleanliness, grooming and general well-being. Procedures included to brush and comb hair daily, sign up for haircuts as necessary through the barber/hairdresser service available. COMPLAINT DEFICIENCY	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to assess and monitor two additional skin areas that were observed by the hospice aide during incontinence care on 7/7/21 to Resident #35's bilateral feet. The findings included:	F 684	**F 684** **1. Resident #35 had complete skin assessment for any skin concerns. Areas identified, treatment and place and care plan is current and accurate.** **2. Current residents have the potential to be affected by this deficient practice. Skin checks completed on current residents for any areas and addressed as needed.** **3. Nursing staff educated on skin and wound process to include, recognition, documentation and treatments by Director of Nursing/designee. Education will be completed for agency and new nursing employees upon hire.** **4. Director of Nursing/designee will review weekly skin checks and new admissions for any new areas, current wounds(for treatment and measurements) weekly for 12 weeks to ensure skin issues and treatments are done timely and appropriately. Results of audits to QAPI commit monthly X 3 for review and revisions as needed.** **5. Date of compliance**	8/9/2

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F 684	Continued From page 51 Resident #35 was admitted to the facility on 12/9/20 and readmitted on 2/16/21 with diagnoses that included but were not limited to chronic heart failure, spinal stenosis, and chronic embolism and thrombosis of unspecified deep veins of lower extremity (bilateral). Resident #35's most recent MDS (Minimum Data Set Assessment) was a quarterly assessment with an ARD (assessment reference date) of 5/20/21. Resident #35 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status exam). On 7/6/21 at 3:32 p.m., an interview was conducted with Resident #35. Resident #35 had mentioned to this writer that facility staff do not provide him with incontinence care when they know his hospice aide will be in the building. Resident #35 stated that his hospice aide usually shows up at 9:50 AM three times a week. Resident #35 stated that his brief will not be checked the entire morning by facility staff if it's a scheduled hospice day. On 7/7/21 at 8:52 a.m., Resident #35 was sitting up in his bed eating breakfast. Resident #35 stated that the last time he was changed was at 4 a.m. Resident #35 stated that staff have not been in his room to check him since then. Resident #35 stated that his hospice aide should be coming in to bathe him at 9:50 a.m. Resident #35 stated that he was wet at that time. On 7/7/21 at 9:52 a.m., bathing and incontinence care was observed with the hospice aide. Resident #35 had a BM (Bowel Movement) but was not heavily soiled. During bathing care; the	F 684		

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F 684	Continued From page 52 hospice CNA lifted the sheets off Resident #35's feet. Resident #35's feet were laying directly on his pillows rather than being floated off the pillows. Resident #35 already had two documented known pressure sores to his bilateral heels. Resident #35's bandages were in place. A tiny open area with a pink wound bed was observed to the bony prominence of the right and left foot, near the pinky toes. These areas were not covered with a dressing. Both areas were draining a scant amount of serous drainage onto the pillows. The hospice aide stated that at that moment, was the first time she had noticed the areas to his bilateral feet. The hospice aide stated that she was in the facility the day prior (7/6/21) but that facility staff had bathed him already. Resident #35 then stated, "Ma'am they (facility staff) only did this area (pointing to perineal area) yesterday, so they wouldn't have seen my feet." The hospice nurse then stated that she would let the assigned floor nurse know when she was done providing care. The hospice aide was asked to let this writer know when she notified the floor nurse. Resident #35 then stated to the hospice aide that he wanted to wear his socks because he was going to get out of the bed. The hospice aide then asked if he was sure because she didn't want the socks to stick to his open wounds. On 7/7/21 from 10:45 a.m. until 12:30 p.m., this writer was on the hallway making observations. At 11:01 a.m., the hospice aide was observed telling the floor nurse (LPN Licensed Practical Nurse) #1 that two new areas were found to Resident #35's feet. The hospice aide then came to this writer and stated that she had told the floor nurse about Resident #35's open areas. Review of Resident #35's clinical record, failed to	F 684		

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F 684	Continued From page 53 evidence any recent treatment orders or record of the open areas to his bilateral feet. On 7/7/21 at 6:00 p.m., there was still no evidence of any nursing assessment or follow up for Resident #35's bilateral open areas to his feet. On 7/8/21 at 8:30 a.m. further review of Resident #35's clinical record was completed. A nursing note dated 7/8/21 at 12:49 a.m. documented the following: "Dressing to fee (sic) changed due to soiling." There was no additional evidence that the two new skin areas had been assessed. On 7/8/21 at 10:00 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1, the nurse who was assigned to Resident #35 on 7/7/21. When asked the process if a staff member makes her aware of a new skin area to a resident, LPN #1 stated that she would assess the area, make sure the MD (Medical Doctor) was made aware and then obtain a treatment order from the physician. LPN #1 then stated she would fill out a "Risk Management icon" on the computer system that identifies a new skin area. LPN #1 then stated she would alert her supervisors. When asked if LPN's can stage wounds, LPN #1 stated that she can describe the appearance but not stage. LPN #1 stated that a wound nurse or RN would stage the wounds. When asked if the same process was true for a hospice resident, LPN #1 stated that she would alert the hospice provider regarding a new skin area and then they would alert the hospice MD. LPN #1 stated that she would document that she notified the hospice provider and still do her own assessment. When asked what she did for Resident #35's open areas to his bilateral feet when hospice had made him aware on 7/7/21 at	F 684		

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F 684	Continued From page 54 11:01 a.m., LPN #1 stated, "I don't recall. I know the aide was there." LPN #1 then stated that she did not look at Resident #35's feet at all on 7/7/21. LPN #1 then stated that she hadn't worked the section Resident #35 had resided in a few months. LPN #1 stated that she may have been distracted with passing out medications that she may not have been hearing what the hospice aide was telling her. LPN #1 stated that if she wasn't distracted and heard the aide, she would have addressed it. On 7/8/21 at 3:10 p.m., an interview was conducted with LPN #3, Resident #35's floor nurse. When asked if she was made aware that Resident #35 had two new areas to his bilateral feet; LPN #3 stated that she was not made aware. LPN #3 stated that she hadn't looked at his feet on her shift. This writer asked her to assess Resident #35's feet. Upon observation of Resident #35's feet; the two new areas appeared to have scabbed over. His feet were again laying directly on his pillows rather than floated. LPN #3 stated that his areas appeared to be closed now. LPN #3 then stated to this writer, "Do you want me to put anything on it?" This writer informed the nurse that advice could not be given. On 7/8/21 at 3:15 p.m., an interview was conducted with LPN #4, the nurse who dressed Resident #35 bilateral heels at midnight that morning. LPN #4 was not made aware of any new skin areas to his bilateral feet at the bony prominences. LPN #4 stated that she did not notice any new open areas while doing his dressings that morning. When asked if she is supposed to look at the entire foot when doing a dressing change; LPN #4 stated that she was supposed to assess the skin of the entire foot	F 684		

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F 684	Continued From page 55 when providing a dressing change. On 7/8/21 at 4:07 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), and ASM #3 the corporate nurse were made aware of the above concerns.	F 684		
F 686 SS=G	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, resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to obtain a treatment for pre-existing pressure ulcer* that had later declined to an unstageable (1) pressure ulcer for one of 41 residents in the survey sample; Resident #35 AND failed to provide treatment and services to promote the healing of a pressure sore for one of 41 residents; Resident #74. *Pressure Injury (ulcer) - A pressure injury is localized damage to the skin and underlying soft	F 686	**F 686** **1. Resident #35 complete skin assessment for any skin concerns. Areas identified, treatment in place and care plan is current and accurate.** **2. Current residents have the potential to be affected by this deficient practice. Skin checks completed on current residents for any areas and addressed as needed.** **3. Nursing staff educated on skin and wound process to include; recognition, documentation and treatments by Director of Nursing/designee. Agency and new hired nursing staff will be educated on hire.** **4. Director of Nursing/designee will review new admissions and weekly skin checks for any new areas, current wounds(for treatment and measurements) for 12 weeks to ensure skin issues and treatments are done timely and appropriately. Results of audits to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of compliance:**	8/9/21

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F 686	Continued From page 56 tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. https://npuap.org/page/PressureInjuryStages. The findings included: Resident #35 was admitted to the facility on 12/9/20 and readmitted on 2/16/21 with diagnoses that included but were not limited to chronic heart failure, spinal stenosis, and chronic embolism and thrombosis of unspecified deep veins of lower extremity (bilateral). Resident #35's most recent MDS (Minimum Data Set Assessment) was a quarterly assessment with an ARD (assessment reference date) of 5/20/21. Resident #35 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status exam). Resident #35 was coded in Section M (Skin Conditions) as having a stage 4 (2) pressure ulcer. On 7/6/21 during an interview with Resident #35; Resident #35 had stated that he had come into the facility with a pressure ulcer but that he didn't feel that the facility was doing dressing changes like they should have been and that the wound had worsened. Review of Resident #35's facility admission note dated 12/9/20 documented in part, the following: " Resident Arrival Date and Time: 12/09/2020 6:00	F 686		

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F 686	Continued From page 57 PM...Open area to coccyx present 1.5 X 2.5 cm (centimeters) x 0.1 cm...Braden: 13.0 (3)." The next note dated 12/9/20 documented the following: "Note Text: Wound type is pressure. Stage: 2 (4) Wound Location coccyx. Length (cm) 1.5, Width (cm) 2.5, Depth (cm) 0.1 Area is community acquired. Skin impairment was present on admission. 12/09/2020 Drainage type: Serosanguineous Drainage Small Drainage, Wound bed is Red No odor, Area is a new wound. Pain Level is 0 Family notified 12/10/2020 9:00 AM. Physician Aware: 12/10/21...Treatment: (No treatment was documented). Review of a physician note dated 12/10/20 revealed that the physician was aware of Resident #35's wound to his sacral area. The following was documented: "...new sacral lesion about 2 x 1 cm stage II it was noted by the staff..." There was no evidence that orders for a treatment were obtained. Review of the physician order summary for December 20201 revealed that an order for the sacral wound was not put into place until 12/14/20 (5 days later). The following was documented: "Treatment as follows: cleanse sacrum area with normal saline, apply skin barrier wipe to periwound area, apply Dermagel Hydrogel Sheet dressing, cover with gauze and tape or non-adherent dressing. Change every three days and prn (as needed)." There was no evidence on the December 2020 TARs (Treatment Administration Record) or MARS (Medication Administration Record) that the 12/14/20 order was implemented.	F 686		

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F 686	Continued From page 58 On 12/12/20 there was evidence that the primary physician had conducted a partial assessment on the sacral wound on 12/12/20. The following was documented in part, "a sacral stage II skin breakdown about 1 x 2 cm with no secondary infection cellulitis or tunneling..." Description of the wound bed, periwound etc. was not mentioned in the above assessment. Review of a weekly wound assessment dated 12/15/20; revealed that Resident #35's sacral wound had deteriorated. The following was documented: "Wound Type: Pressure. Stage: Unstageable. Wound Location: sacrum. Length: 7 (cm) by Width (13 cm) Depth nonmeasure...was skin condition present upon admission? Yes...Drainage: Serous. Drainage Amount: Scant. Odor. None. Wound Bed appearance: necrotic...Odor: none. Peri wound appearance: Red...DRESSING TREATMENT PLAN. Primary Dressing(s) Dakin's solution (5) apply once daily. Santyl (6) apply once daily. Secondary Dressing(s) Gauze Island (w/bdr) apply once daily. Peri Wound Treatment Skin prep apply once daily...This wound is in an inflammatory stage and is unable to progress to a healing phase because of the presence of a biofilm." Review of the Resident #35's December 2020 MAR (Treatment Administration Record) revealed that this order was implemented on 12/17/20. Review of a note by the wound care physician dated 12/22/20 documented in part, the following: "At the request of (Name of physician) a thorough wound care assessment and evaluation was performed today. He has an unstageable (due to necrosis) sacrum for at least 8 days in duration. There is light serous exudate...Wound Stage: 8.0	F 686		

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F 686	Continued From page 59 x 10.0 x Not Measurable cm. Periwound radius: Odor...Thick adherent black tissue: 50 % (percent) Thick adherent devitalized tissue: 20 % Granulation tissue: 20 % Skin: 10 % (percent). Wound progress: Deteriorated." Review of Resident #35's care plan dated 12/9/20 through 6/2/21 revealed a skin integrity care plan was not put into place until 12/30/21. The following was documented, in part: "Resident has impaired skin integrity- Unstageable PU (pressure ulcer) to sacrum present on admission...administer treatments as ordered, Encourage (Name of Resident #35) to turn and reposition while in bed, monitor nutritional status. Consult dietician." Review of Resident #35's December 2020 POS (Physician Order Summary) also revealed that no skin prevention measures were put into place until 12/16/20 when he was ordered an "alternating pressure mattress and "double protein meat" from the dietician. On 7/8/21 at 10:00 a.m., an interview was conducted with LPN (Licensed practical nurse) #1, a nurse who worked with Resident #35 on occasion. When asked who was responsible for assessing a wound upon admission into the facility, LPN #1 stated that it was the floor nurse who was responsible for measuring the wound and providing a description of the wound. LPN #1 stated that LPNs could not stage but that an RN could stage a wound. LPN #1 stated that if the resident is not admitted with a treatment order on the hospital discharge instructions, it is up to the nurse to call the MD (medical doctor) for an order. LPN #1 was shown the admission note for Resident #35 on 12/9/21. LPN #1 was then	F 686		

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F 686	Continued From page 60 shown the December 2020 POS (physician order summary) and the December MARs and TARS for 2020. LPN #1 confirmed that she did not see that a treatment was put into place once his wound was identified upon admission as a stage two. When asked the consequence for not doing a dressing to an identified stage two ulcer, LPN #1 stated that the wound could get worse. LPN #1 was then shown that on 12/15/20 (Next weekly wound assessment) Resident # 35's wound had gotten bigger and was found to have necrotic tissue to the wound bed. LPN #1 stated, "Yes, it looked like it had deteriorated." When asked what necrotic tissue was, LPN #1 stated that necrotic tissue was "dead tissue" that was black in color. LPN #1 stated that necrotic tissue has to be debrided in order for healing to occur. On 7/8/21 at 12:16 p.m., an interview was conducted with RN (Registered Nurse) #2, the unit manager for unit one and two. When asked if nursing staff were expected to assess and obtain a treatment order for a newly admitted resident who is admitted to the facility with an existing pressure ulcer, RN #2 stated, "Yes, I expect the nurses to assess get a treatment order for that wound." When asked the consequence if an order for a treatment is not obtained for a pressure ulcer, RN #2 stated that it could lead to the wound deteriorating. When asked what necrotic tissue meant to the wound bed, RN #2 stated that necrotic tissue was dead tissue. RN #2 stated that if necrotic tissue is in the wound bed, the wound will not heal until it has been removed. When asked if necrotic wounds are considered advanced stage wounds, RN #2 stated that they were. This writer had discussed the above findings with RN #2. RN #2 was asked to present any additional information regarding	F 686		

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F 686	Continued From page 61 Resident #35's sacral wound. RN #2 was made aware that if this information was not found; this citation could lead to a serious scope and severity level. On 7/8/21 at 12:30 p.m., ASM #1, the Administrator was made aware of what was discussed with RN #2 and that documentation was needed to show that a treatment was put into place and implemented on 12/9/20 through 12/14/20 prior to the wound deteriorating. On 7/8/21 at approximately 3:00 p.m., RN #3, the MDS nurse presented Section M (Skin Conditions) of Resident #35's MDS assessment with an ARD date of 12/15/20. RN #3 stated that the look back period for this particular MDS was on 12/8/20 through 12/15/21. RN #3 stated that there had to have been an order in place if she had checked that Resident #35 was receiving dressings and ointments. The following was documented on this MDS and signed by the MDS nurse on 12/29/20: "A. Resident has a pressure ulcer/injury, a scar over a bony prominence, or a non-removable dressing/device: Yes; B. Formal Assessment: Yes. C. Clinical Assessment: Yes....M0210. Unhealed pressure Ulcers/Injuries: Yes. M0300. Current number of unhealed pressure ulcers/injuries: F1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar: (1)...F2. Number of these unstageable pressure ulcers that were present upon admission or reentry: (1)." Section F2 was inaccurate as it was documented in the clinical record that Resident #35 was admitted to the facility with a stage two ulcer.	F 686		

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F 686	Continued From page 62 Further review of the Section M of Resident #35's MDS documented the following: "...Application of nonsurgical dressing (with or without topical medications) other than to feet: Yes. H. Application of ointments medications other than to feet: Yes." There was no still no evidence that a treatment order was obtained and implemented after Resident #35 was admitted to the facility with a stage two pressure ulcer; AND there was no evidence that Resident #35 was receiving any type of ointment or barrier cream. On 7/8/21 at 3:15 p.m., a phone interview was conducted with the nurse who admitted Resident #35 on 12/9/20. She could not recall if Resident #35 had been admitted with a wound and if an order was obtained or not. On 7/8/21 at 4:00 p.m., ASM #1, the Administrator; ASM #3 and #4 the Corporate Nurses were made aware of the concern for harm. ASM #4 stated that they still could not find the treatment order for the stage II wound during 12/9/20 through 12/14/20 or a TAR showing that the order was implemented. ASM #4 stated that the orders and TAR were probably written on paper back when they were doing paper charting. ASM #4 stated that the 12/15/20 MDS however reflected that Resident #35 had an order in place because the MDS RN had signed and locked the MDS which indicated that all information on the MDS was accurate. This writer informed ASM #4 that the signature means that the section was completed, not that the information was accurate. On 7/8/21 at the exit conference held at 6:30	F 686		

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F 686	Continued From page 63 p.m., ASM #4 stated that she was still looking for TAR and order. This information could not be presented prior to exit. No further information was presented prior to exit. Facility Policy titled, "Pressure Injury Prevention and Treatment Policy," documents the following: "Resident's will be assessed for pressure injury risk on admission, quarterly, and with significant change of condition using the Braden Scale for Predicting Pressure Ulcer Risk. Wounds identified will be assessed initially and at least weekly thereafter, until closed. To include the following elements: Location and stage Size (perpendicular measurements of the greatest extent of length and width of the ulceration), depth and the presence, location and extent of any undermining or tunneling/sinus tract; Exudate, if present: type (such as purulent/serous), color, odor, and appropriate amount; Pain, if present: nature and frequency (e.g., whether episodic or continuous); Wound bed: Color and type of tissue/character including evidence of healing (e.g. granulation tissue, maceration) as appropriate; Appearance of surrounding tissue; Any evidence of infection If a PU (Pressure Ulcer)/Pressure Injury) fails to show some evidence of progress towards healing within 2-4 weeks, the area and the resident's overall clinical condition will be reassessed. B. Treatment: Pressure injuries identified will be documented and orders obtained from providers for treatment. C. Monitoring: At least weekly (and	F 686		

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F 686	Continued From page 64 more often when indicated by wound complications or changes in wound characteristics), an evaluation of the PU/PI will be documented. At a minimum, documentation will include the elements listed in Section A. D. Notification: The facility will notify family/resident representative[s] and the provider of any newly acquired or worsening pressure injuries and any changes in treatment[s]." (1) Unstageable pressure ulcer- "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description: Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed." National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (2) Stage 4 pressure ulcer- Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. Further description: The depth of a stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Stage IV ulcers can extend into muscle	F 686		

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F 686	Continued From page 65 and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable." National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. (3) The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development ...The Braden Scale is a summated rating scale made up of six subscales scored from 1-4 (1 for low level of functioning and 4 for the highest level or no impairment). Total scores range from 6-23 (one subscale is scored with values of 1-3, only). The subscales measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure, or lower tissue tolerance for pressure. A lower Braden Scale Score indicates lower levels of functioning and, therefore, higher levels of risk for pressure ulcer development. This information is taken from the website https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_BRADEN/ (4) Stage 2 pressure ulcer- Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.	F 686		

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F 686	Continued From page 66 (5) Dakin's solution is used to prevent and treat skin and tissue infections that could result from cuts, scrapes and pressure sores. This information was obtained from: https://www.webmd.com/drugs/2/drug-62261/dakins-solution/details. (6) Santyl- *SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>) 2. Resident #74 was admitted to the facility on 11/20/2020 and discharged to the hospital on 12/03/2020. Diagnosis included but were not limited to, Cellulitis of left lower limb and Type 2 Diabetes Mellitus without complications. Resident #74's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 11/26/2020 was coded with a BIMS (Brief Interview for Mental Status) score of 09 indicating moderate cognitive impairment. In addition, the Minimum Data Set coded Resident #74 as requiring supervision with setup help only with eating, limited assistance of 1 with bed mobility, extensive assistance of 1 with transfer and personal hygiene and total dependence of 1 with bathing. On 07/06/2021 review of Resident #74's clinical record revealed the following: Admission Progress Note dated 11/20/2020 15:10 was reviewed and revealed the following:	F 686		

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F 686	Continued From page 67 ".....has MASD (Moisture Associated Skin Damage) to the buttocks area with redness and excoriation, with an open area to the rt (Right) buttocks 0.5 x 1 x 0 MD (Medical Doctor) notified, moisture barrier cream applied..... Braden: 13.0" Pressure / Non Pressure Skin Assessment Progress Note dated 11/20/2020 15:10 was reviewed and revealed and is documented in part, as follows: Note Text: Wound type is MASD Wound Location buttocks Length (cm) (Centimeter) 0.5 Width (cm) 1 Depth (cm) 0 Area is community acquired, no skin impairment was present on admission. 11/20/2020 Drainage type: No Drainage Wound bed appearance is Pink No odor Periwound appearance is Pink. Area is a new wound. Pain levels 0 11/20/2020 12:00 AM Treatment: moister [sic] barrier cream waiting on further orders from MD. Review of Physician Orders revealed the following: "ORDERS Admit To Colonial Health & Rehab Diagnosis: CHF (Congestive Heart Failure) Allergies: Bactrim, Cymbalta, Amoxicillin, Latex Diet: Cardiac Diet Code Status: DNR (Do Not Resuscitate) / DNI (Do Not Intubate) Verified By (Name of Medical Doctor) Other #1. 11/20/20 Medications Treatments "Wound MD eval (Evaluate) and treat." Review of orders did not evidence a treatment order for buttocks or sacrum. On 07/07/2021 requested copies of the Medication Administration Records (MAR) and Treatment Administration Records (TAR) for November 2020 and December 2020 and Braden scores for Resident #74.	F 686		

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F 686	Continued From page 68 On 07/07/2021 requested copy of Resident #74's wound measurement from admission to discharge. Copy of Weekly Wound Assessment v1 - V5 was received. Review of assessment revealed the following: Effective Date: 11/20/2020 15:10 Admission: 11/20/2020 1. Wound Overview 1. Wound Type 10. Other; 1a. Other Wound Type MASD; 2. Wound Location: buttocks; 3. Length (cm) 0.5; 4. Width (cm) 1; 5. Depth (cm) 0; 6. Location Where Wound Was Acquired? 2. Community Acquired 2. Wound 1. Was the skin impairment present on admission 1? Yes; 3. Date Wound Identified 11/20/2020 6. Wound Bed Appearance 1. Pink; 8. Periwound Appearance 1. Pink; 10. Wound Status 1. New Wound; 4. Comments and Treatment 2a. Date and Time Physician Notified: 11/20/2020 00:00; 3. Treatment moister [sic] barrier cream; 4. Comments waiting on further orders from MD. On 07/07/2021 at 6:30 p.m., received copies of Resident #74's MAR and TAR for December 2020 from the Director of Nursing (DON). The Director of Nursing stated, "We are still looking for November MAR and TAR." Resident #74's TAR received for the Month of December was reviewed on 07/07/2021 and revealed the following: Medications - Calmoseptine after each incont (Incontinent) episode. In the column under HOUR, Day, Night is documented. Resident #74's Admission / Readmission Evaluation - V 2 completed on 11/21/2020 was reviewed on 07/07/2021 and revealed the following: Skin Risk Score: 13 Skin Risk Category: Moderate risk.	F 686		

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F 686	Continued From page 69 On 07/07/2021 review of Physician / PA (Physician Assistant) / NP (Nurse Practitioner) Progress Note dated 11/23/2021 14:19 in Resident #74's clinical record revealed the following: genitourinary: genitals unremarkable, there is some moisture associated skin damage with erythema on most of the buttocks area it's completely covered with calmoseptine there is some mild skin breakdown on the right buttocks it only appears to be about one or 2 cm but I could not get the calmoseptine off at this time she said it was too uncomfortable and wish to just leave it on. Did not see any other lesions. Review of Resident #74's Nursing Progress Note dated 11/24/2021 revealed and is documented in part, as follows: Note Text: Wound Doctor in to see patient today. MASD to bottom healing, no open areas just redness, barrier cream and calmoseptine applied. Resident #74's Braden Scale Pressure Ulcer Risk Assessment with an Effective date of 11/27/2021 was reviewed on 07/07/2021 and revealed the following: Braden Score: 18 Braden Category: Low Risk. On 07/07/2021 Resident #74's Bi-Weekly Skin Check 1 with a date of 11/29/2021 was reviewed and revealed the following: 1. Does the resident have current Skin Issues 1. Yes Document current Skin Issues Site 53) Sacrum Description redness. On 07/07/2021 Resident #74's Bi-Weekly Skin Check 1 with a date of 12/2/2021 was reviewed and revealed the following: 1. Does the resident have current Skin Issues 1. Yes Document	F 686		

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F 686	Continued From page 70 current Skin Issues Site 53) Sacrum Description redness. On 07/08/2021 at approximately 10:00 a.m., an interview was conducted with (Name of Doctor) Medical Doctor (MD) Other #6. When MD was told that surveyor had a couple questions for him regarding Resident #74, MD stated, "I think I saw her maybe one time." When asked about Resident #74's admission orders, MD stated, "We order what the hospital recommends, whatever the hospital ordered." When asked what the process for ordering resident medications is, MD stated, "The nurse sends the orders from the discharge summary to the doctor, these are the medicines the hospital placed the patient on. If the doctor is not in the facility the staff would have to read the orders from the Discharge Summary over the telephone and not all medications are approved for different reasons." MD stated the last time he saw Resident #74 was December 2. MD stated, "She had calmoseptine on every time I saw her." When asked was Calmoseptine an acceptable treatment for her buttocks, MD stated, "Yes, it is a barrier cream." MD also stated, "It keeps urine and poop off of the skin and it makes it slower for the skin to dry out." Review of Resident #74's clinical record for the period of 11/20/2020 through 11/30/2020 revealed documentation that staff applied barrier cream and /or Calmoseptine to resident on 11/20/2020, 11/23/2020 and 11/24/2020. There is no evidence that the resident was provided treatment to wounds consistently or had a wound treatment order during this time. On 07/08/2021 Resident #74's hospital records was reviewed and revealed the following: (Name	F 686		

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F 686	Continued From page 71 of hospital) Emergency Department Time of Arrival: 12/03/20 0806 ED (Emergency Department) Provider Note Physical Exam Skin: Comments: Stage II decubitus ulcer in the sacral area this appears overall to be well - healed with some surrounding areas of erythema and stage I ulceration.; Progress Notes by (Name of Nurse) RN (Registered Nurse), Other #7 at 12/4/2020 0203 Skin Image 5: Large area skin breakdown with several open areas. Non-blanching redness. Received patient from ED alert and oriented..... Skin assessment completed, skin care provided. (Review of Skin Image Diagram indicates 5 is in the sacral region.) On 07/08/2021 at approximately 3:45 p.m., an interview was conducted with the Director of Nursing. When asked do you have any other wound measurements or Weekly Wound Assessments for Resident #74 buttocks or back, Director of Nursing stated, "No." When asked do you have the MAR and TAR for November 2020, DON stated, "We cannot find the MAR and TAR for November." When asked what is the MAR and TAR, DON stated, "They are records to document what medications were administered and what treatments were given." When asked do you have the Physician Order Summary (POS) for November 2020, DON stated, "I don't see a treatment for the buttocks on the POS." When the DON asked for a copy of the POS provided a copy of the Physician Admission orders. When asked were there any orders written for treatments to the buttocks after the admission order, DON stated, "No, I don't see anything in here." When asked should the resident had a treatment ordered for her MASD and wound on her buttocks, DON stated, "Yes." When asked	F 686		

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F 686	Continued From page 72 what your expectations of nurses are when a resident has a wound, DON stated, "See if treatment came over from the hospital and if it did not then to obtain a treatment order from the physician." When asked why should wounds and impaired skin integrity have a treatment, DON stated, "to help promote healing." On 07/08/2021 at approximately 6:00 p.m. Administrator and Director of Nursing was informed of findings at pre-exit meeting. The facility did not present any further information about the finding.	F 686		
F 689 SS=D	Complaint Deficiency 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 observations, clinical record reviews, staff and resident interviews, the facility staff failed to ensure 2 of 41 residents (Resident #49 and #37) were free of accident hazards. The sit-to-stand mechanical lift was not used in accordance to assessed need to prevent possible accidents for Resident #49, and that fall preventative measures, to include fall mats, were consistently in place to protect from potential fall	F 689	**F 689** **1. Resident #49 was evaluated for appropriateness of sit to stand lift and resident #37 bedside mats were placed down while resident in bed. Care plans reviewed and are current with plan of care.** **2. a. Residents with falls have potential to be affected by deficient practice; residents with falls since 7/1/2021 reviewed for appropriate interventions.** **b. Residents with greater than minimal assist for transfers were assessed for appropriate transfer method to include appropriate lift if needed.** **3. Nursing staff educated on appropriate use of lifts by rehab director/designee. Nursing educated on fall interventions and ensuring in place by Director of Nursing/designee. Agency and new hired nursing staff educated on hire.**	

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F 689	Continued From page 73 injuries for Resident #37. The findings include: 1. Resident #49 was admitted to the nursing facility on 8/1/19 with diagnoses that included bipolar disorder, type 2 diabetes mellitus, depression, age related osteoporosis, restless leg syndrome and incomplete paraplegia. The most recent Minimum Data Set (MDS) was a quarterly dated 4/6/21 that coded Resident #49 on the Brief Interview for Mental Status (BIMS) with an 11 out of a possible score of 15 that indicated the resident was moderately impaired in the skills for daily decision-making. The resident was assessed to require extensive assistance of two staff for transfers nor was she able to balance herself during transitions without staff assistance and had impairment on both sides of lower extremities in range of motion. The resident used a wheelchair as the normally used mobility device. The care plan dated 4/3/21 identified that the resident had an ADL self-care performance deficit related to lower extremity paraplegia. The goal set by the staff for the resident was that she would maintain current level of function. Some of the interventions to accomplish this goal included transfers with the sit-to-stand mechanical lift with two staff members. The last physical therapy evaluation and plan of treatment was dated 2/4/20 and identified Resident #49 was a fall risk, unable to perform dynamic or static standing balance; totally dependent on staff. The resident had her own sliding board and preferred to use it for transfers to safely perform functional transfers in order to	F 689	**4. Rehab director/designee will audit 5 residents weekly for 12 weeks to ensure appropriate transfer. Director of Nursing/designee to audit 5 residents to ensure fall interventions are in place care planned appropriately. Results of audits to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of Compliance:** 8/9/21	

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F 689	Continued From page 74 facilitate increased participation with functional daily activities. The evaluation indicated the resident had the ability to use a slide board for transfers and transitioned to a Sara (sit-to-stand) mechanical lift by nursing staff decision. The following observations were made of Resident #49 during transfers with the sit-to-stand mechanical lift: On 7/6/21 at 2:29 p.m., Resident #49 was transferred via the sit-to-stand mechanical lift from the bed to her wheelchair by her assigned CNA #3, assisted by CNA #4. The sling was attached around the patient's back just above the base of the spine with her arms outside of the sling. There were no belt placed around the resident's waist. There were two top straps connected to sling with interval color coded loops. The CNAs attached the top straps at the blue loop to the each of the two center knobs. There were three colored loops, blue, green and purple. When asked why the blue loop was used, CNA #3 stated, "I am not sure, it is the one I think pulls her forward in the best position because she does not bear weight at all with her legs." The resident's feet were placed on the platform of the lift and her knees touched the kneepads. The resident placed her hands on each of the handlebars. The leg straps were not utilized and hung free on each side. As the CNAs used the remote control to raise the resident, she never came to a standing position, but stayed in a sitting position with her body hanging as the CNA's transported the resident to the wheelchair. On 7/7/21 at 12:45 p.m., CNA #3 assisted by CNA #7 transferred Resident #49 as previously observed, but used the green loop attached to	F 689		

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F 689	Continued From page 75 each of the two center knobs. On 7/8/21 at approximately 12:00 p.m., the aforementioned concerns from the resident was shared with the Administrator. On 7/8/21 at 2:30 p.m., CNA #2 and another CNA transferred Resident #49 via the sit-to-stand mechanical lift from the bed to her wheelchair as observed in previous transfers, but this time the purple loop was attached to each of the two center knobs. When asked why the purple loop was chosen, the CNA stated, "I used it before." CNA#2 said the resident was not able to stand or bear weight and that was the reason she used the sit-to-stand lift. During all of the transfers, the resident never came to any form of standing, but hung in the sling during the transfer process. On 7/8/21 at 2:45 p.m., an interview was conducted with the Director of Rehabilitation (Rehab). She stated, "I do not make assessments for the use of mechanical lifts. I evaluate their upper and lower body strengths, muscle testing and balance." The Director of Rehab printed the last Physical Therapy PT) evaluation dated 2/4/20 which indicated the optimal transfer method for the resident at that time was with a sliding board, but nursing was using the Sara-lift for transfers. The Director of Rehab also printed the lift program skills check-off sheet for the sit-to-stand and said staff persons using any lift were required to complete and keep in their training records. On 7/8/21 at 3:00 p.m., the Director if Rehab along with the Director of Housekeeping/Laundry	F 689		

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F 689	Continued From page 76 located all the slings, but could not locate one specific to the Sara sit-to stand. They located the sit-to-stand lift and the sling was hanging on the lift. Another PCA (#1) was asked if she could demonstrate how to place the sling on a resident and utilize the lift. She demonstrated on the body of the Director of Rehab. The CNA placed the sling on the Director of Rehab as had been observed with the previous CNAs. The Director of Rehab grabbed the leg straps and began to bring them under each leg to secure to the knobs on the sit-to-stand. This surveyor asked why she proceeded with that process and responded, "It looks like this would provide support for the resident if they were not able to stand to facilitate the transfer safely." PCA#1 stated he used the leg straps for the very same reason and said, "I have one resident who needs them because of weakness, but the other resident stood well enough to bare some of her weight. It is a safety issue. Most of the time it is okay to use the top straps and attach to the sit-to stand as long as the resident can bear some weight and hold on. They should never look like they are hanging from the sling, may lose grip and slip through." The Rehab Director agreed with the PCA and stated she was going to screen and evaluate Resident #49 for her upper and lower body muscle strength and determine if she experience any decline. She stated the resident might need the full mechanical lift to ensure her safety with transfers. The Director of Rehab stated, "I don't know anything if I am not told by the nursing staff." Neither the PCA could explain the significance of the loop colors. On 7/8/21 at 3:25 p.m., the Director of Nursing (DON) was asked for the training on the sit-to stand for the CNA #3 and PCA#2. The DON was	F 689		

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F 689	Continued From page 77 shown the lift program, skills check off sheet for the Sara 3000 that was presented by the Director of Rehab. The DON responded, "She believed" the facility used the Sara 3000. On 7/8/21 at 4:30 p.m. The DON was not able to locate those training records nor the training for all staff on the sit-to stand. On 7/8/21 at 6:00 p.m., a debriefing was conducted with the Administrator, the Director of Nursing and Corporate Nurse #3. The DON stated she expected the therapy department to assess residents and determine the safest method for transfers. It was shared by this surveyor that the Director of Rehab stated she did not assess for the use of lifts; she assesses the resident's functional strengths. No further information was provided prior to survey exit. The Lift information provided by the Director of Rehab was a skills check off sheet with instructions for the use of the Sara 3000 was not dated, but indicated it was used for extensive assist or partial weight bearing patients, taking patients from a seated position to a standing position to assist with transfers. The sheet asked the question, "Can the patient bear weight through at least one leg? If answered no possible alternatives include the (names of total lifts)." Other questions included, "Does the patient have adequate upper body strength and ROM?" The lift education included how to attach the sling to the resident and operate the lift. One essential detail included raising the resident to a standing position on the platform of the lift and to fasten both of the leg supports if added security was desired or needed which was not used for Resident #49's safety in that she did not bear weight on either leg. There was no information	F 689		

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F 689	Continued From page 78 regarding the significance of the color-coding of the variable loops. The Director of Rehab included the recommended general sling selections for the total lift with color-coding of the slings, which was based on weight of the resident. 2. Resident #37 was admitted to the facility on 1/23/21 with diagnoses that included but were not limited to muscle weakness, unspecified abnormalities of gait and mobility, and sepsis. Resident #37's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 5/19/21. Resident #37 was coded as being intact in cognitive function scoring 14 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #37 was coded as requiring supervision only with transfers, and ambulation; AND limited assistance with one staff with bed mobility. Resident #37 was coded in section J1900. (Falls) as having 2 falls since admission; one with no injury and one with injury (but not major). Review of Resident #37's clinical record revealed that Resident #37 had fallen on the following dates: 1/28/21 with no injury; 5/6/21 with no injury; 6/08/21 with injury; and 6/17/21 with no injury. Review of Resident #37's comprehensive care plan dated 2/2/21, documented in part, the following: "(Name of Resident #37) is at risk for falls... (Name of Resident 37) will have no injuries related to falls over the next review. Interventions: Fall mats date initiated (2/2/21)..."	F 689		

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F 689	Continued From page 79 On 7/6/21 at 4:22 p.m., an observation was made of Resident #37. Resident #37 was lying in bed. A large purple bruise was noted to Resident #37's left eye and cheekbone. She did not have a fall mat in place while she was in bed. On 7/7/21 at 8:30 a.m. and 11:15 a.m., observations were made of Resident #37 laying up in bed. Fall mats were not on the floor per plan on care. On 7/8/21 at 10:46 a.m., an observation was made of Resident #37 lying in bed. She did not have a fall mat on the floor per plan of care. On 7/8/21 at 10:48 a.m., an interview was conducted with CNA #3, the CNA assigned to Resident #37 that day and an agency CNA. When asked how should would determine what each of her resident's needed as far as ADL care, fall prevention interventions etc.; CNA #3 stated that she started working at the facility on Tuesday and that her PCC access code was not working until that day 7/8/21. CNA #3 stated that this was her first morning working on the one side of the 100 hall unit. When asked how she knew if someone was a fall risk; CNA #3 stated that that information was usually in the care plan or kardex for aides to use but since she did not have access to those items prior to that day; she was asking the nurses and looking for a sign that was usually in front of the door. CNA #3 stated that facilities will usually put a leaf sign in front of the rooms for residents who at risk for falls. When asked if Resident #37 was a fall risk; CNA #3 stated, "I am not quite sure. I did see that bruise. I think she fell out of her wheelchair for that fall." When asked if Resident #37 required fall mats while in bed, CNA #3 stated that she was not	F 689		

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F 689	Continued From page 80	F 689		

positive; that she would check the kardex now. CNA #3 then with this surveyor checked Resident #37's nursing kardex. CNA #3 then stated that the kardex was showing that Resident #37 was supposed to have a fall mat. CNA #3 stated, "I am just now getting this information. I didn't even see a mat in her room." CNA #3 denied the nurse making her aware that Resident #37 needed a fall mat down while she was in bed.

On 7/8/21 at 12:16 p.m., an interview was conducted with RN (Registered Nurse) #2, the unit manager for unit one and two. When asked how it was determined what was put into place for a resident who has a had a fall; RN #2 stated that the IDT (Interdisciplinary team) will review falls, and come up with an intervention that makes sense; that is specific to that resident. RN #2 stated that the care plan and the kardex will then be updated. When asked if agency nurses had access to the care plan or kardex; RN #2 stated that they received a code from human resources at the start of their shift to access PCC (Point Click Care). When asked if these access coded always functioned properly; RN #2 stated, "Not always" but that the employee can go back to human resources for a code reset. When asked if Resident #37 was supposed to have fall mats down while she was in bed, RN #2 looked at the care plan and stated, "Yes, fall mats should be down." This writer informed her of the above observations.

On 7/8/21 at approximately 12:30 p.m., an interview was conducted with OSM (Other Staff Member) #4, human resources. OSM #4 stated that all agency staff receive an access code prior to the start of their shift to access the computer charting system. OSM #4 stated that there has

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F 689	Continued From page 81 been instances where the code was not working but that if she is made aware right away; she can ask for a reset code. OSM #4 stated that a reset code can be obtained within a few minutes but she has to be made aware of a code not working. Facility policy titled "Incidents/Accident Report," did not address the above concerns. No further information was presented prior to exit.	F 689		
F 695 SS=D	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, resident and staff interviews, clinical record review, the facility staff failed to follow the physician order for the oxygen flow rate for 1 of 41 residents (Resident # 63) in the survey sample. The findings included: Resident #63 was originally admitted to the nursing facility on 03/11/21. Diagnosis for Resident #63 included but not limited to Acute Upper Respiratory Infection. Resident #63's Minimum Data Set (MDS-an assessment protocol) a significant change assessment with an Assessment Reference Date (ARD) of	F 695	**F695** **1. Resident #63 oxygen flow adjusted to correct rate; resident no apparent distress. Care plan reviewed and is current.** **2. Residents currently on oxygen therapy have the potential to be affected by this deficient practice. Audit conducted of residents receiving oxygen therapy to ensure oxygen delivered per order and care plan current.** **3. Licensed nursing staff educated on administration of oxygen therapy as ordered by physician by Director of Nursing/designee. Agency and newly hired licensed nurses will be educated on hire.** **4. Director of Nursing/designee will audit new admissions and 5 residents weekly or 12 weeks receiving oxygen therapy for accurate oxygen administration. Results of audits taken to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of compliance:** 9/9/21	

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F 695	Continued From page 82 06/15/21 coded Resident #63 a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no impaired cognitive skills for daily decision-making. In addition, under respiratory treatments was coded for the use of oxygen therapy. Resident #63's person centered care plan dated 06/10/21 had a focus which read; Resident #63 is on oxygen therapy. The goal read; will be free from signs and symptoms of hypoxia. One of the intervention included; administer oxygen as ordered. Review of Resident #63's Order Summary Report for July 2021 included the following order: Oxygen @ 2 liters minute via nasal cannula with a start date of 06/09/21. During the initial on 7/06/21 at approximately 12:41 p.m. Resident #63 was observed lying in bed with oxygen on at 4 liters minute via nasal cannula (n/c) with humidification. On the same day at approximately 2:51 p.m., Resident #63's oxygen remains on at 4 liter minute via nasal cannula (n/c) with humidification. On 07/07/21 at approximately 4:12 p.m., Resident lying in bed with her oxygen at 4 liters minute via n/c with humidification. On 07/08/21 at approximately 9:43 a.m., the Unit Manager and this surveyor went to Resident #63's room. The Unit Manager went into the room to check Resident #63's oxygen setting. After checking Resident oxygen setting, she replied, "Resident #63 is supposed to be on 2 liters, let me check her orders to make sure she is on the right setting." The Unit Manager	F 695		

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F 695	Continued From page 83 returned, then stated, "The order reads for 2 liters not 4 liters, the Unit Manger decreased the oxygen flow rate to 2 liters. A pre-exit conference was conducted with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/08/21 at approximately 2:40 p.m. The facility did not present any further information about the findings. The facility's policy titled Oxygen Administration (revision date: 12/16/19). -Policy: Licensed clinicians with demonstrated competence will administer oxygen via the specific route as ordered by a provider.	F 695		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 791	**F 791** **1. Resident #30 received dental services on 7/23/20221.** **2. Current residents have the potential to be affected by this deficient practice. Interviewable residents asked about any dental issues; non interviewabe residents were checked for difficulty chewing, mouth odor, and mouth pain.** **3. Nursing Staff educated on identifying resident who may need dental services and reporting any needs by Director of Nursing/designee. Education will be done with Agency and newly hired nursing staff during orientation.** **4. Director of Nursing/designee will assess new admissions for dental issues weekly for 12 weeks. Director of Nursing/designee will ass 5 residents weekly for 12 weeks for any potential dental needs Results of audits will be taken to QAPI Committee monthly X 3 for review and revision as needed.**	8/9/21

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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 791	Continued From page 84 §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review it was determined that facility staff failed to obtain dental services for one of 41 residents, Resident #30. The findings included: Resident #30 was admitted to the facility on 7/3/17 with diagnoses that included but were not limited to heart failure, peripheral vascular disease, neurogenic bladder, dementia without behavioral disturbance and quadriplegia. Resident #30's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 1/18/21. Resident #30 was coded as being moderately	F 791		

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F 791	Continued From page 85 impaired in cognitive function, scoring 08 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam. On 7/6/21 at 2:58 p.m., an interview was conducted with Resident #30. Resident #30 was observed to have some natural teeth; with other missing. Resident #30 stated that his bottom front left tooth was painful, that it felt like his tooth was going into his gums. Resident #30 stated that he could still eat his meals, and that maybe it was contributing to him not eating that much but that he really just didn't feel like eating. Resident #30 stated that he has made staff aware in the past; though he could not specify who he had told. Resident #30 stated, "They know." Resident #30 stated that he has not seen a dentist since he has been in the facility. Review of Resident #30's clinical record revealed that the physician had seen Resident #30 regarding his tooth on 3/22/21. The following in part, was documented: "...Next he's had a fractured left lower incisor that used to have "a cap or a crown" that fell off a long time ago. We been trying to get dentistry to see him there is no secondary infection I can see where it would be painful though...dental referral, hopefully we can still get the dentist come back in the center again. There's no secondary infection to the tooth but it needs to be removed. He is considering asking the dentist if he can have all of his teeth removed and have dentures." Review of Resident #30's July POS (Physician Order Summary) 2021 revealed the following order: "MAY SEE DENTIST No directions specified for order." This order was initiated on 12/13/20.	F 791		

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F 791	Continued From page 86 There was no evidence that after 3/22/21, any attempts were made to get a dental appointment for Resident #30. On 7/8/21 at 11:21 a.m., an interview was conducted with OSM (Other Staff Member) #3, the social worker. When asked who was responsible for coordinating dental visits; OSM #3 stated that she was. When asked how she was made aware that a resident needed to see a dentist; OSM #3 stated that she was usually made aware via a verbal report by nursing. OSM #3 stated that she will then contact the facility dentist. OSM #3 stated that the facility dentist will see any resident regardless of payer status. When asked why Resident #30 had not yet seen the dentist, OSM #3 stated that she was not made aware that Resident #30 had to be seen by the dentist and therefore had not made him an appointment. OSM #3 stated that she will follow up with that. On 7/8/21 at approximately 12:00 p.m., an interview was conducted with RN (Registered Nurse) #2, the unit manager for both Unit one and two. When asked how she is made aware that a resident needs a dental appointment or any other appointment; RN #2 stated that she will get that information through the floor nurse. RN #2 stated that she will then the MD (medical doctor) know and he will assess the patient to let us know if the resident needs a consult. RN #3 stated that the information then goes to the social worker to set up an appointment. When asked when she started as the unit manager in the facility, RN #2 stated she started as the unit manager on 3/15/21 this year. This writer read the MD's note dated 3/22/21 regarding Resident #30's tooth. When	F 791		

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F 791	Continued From page 87 asked if an appointment had been made to address his tooth pain, RN #2 stated that she was not aware that Resident #30 needed a dental consult. RN #2 could not recall this information being conveyed to her. When asked if she reads the physician notes, RN #2 stated she will sometimes but will usually go by any physician orders. This writer made the RN aware that a standing order for dental consult was already in place. On 7/8/21 at 4:07 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), and ASM #3 the corporate nurse were made aware of the above concerns.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842	**F 842** **1. Resident #73 unable to correct practice for past occurrence.** **2. Residents that receive meals by mouth have the potential for not having meal intake documented. Audit of meal consumption completed for 72 hours for trends and patterns.** **3. Nursing staff educated on determining meal percentages and documentation of meal intake by Director of nursing/designee. Education with agency and new hire nursing staff will be done with orientation.** **4. Director of Nursing/designee will audit meal intake documentation 5 times a week for 12 weeks to ensure compliance with documentation. Results of audits to QAPI committee monthly X 3 for review and revision as needed.** **5. Date of Compliance:** 8/9/21	

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F 842	Continued From page 88 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 89 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 in the course of a complaint investigation, it was determined that facility staff failed to maintain a complete record for one of 41 residents in the survey sample; Resident #73. The findings included: Resident #73 was admitted to the facility on 11/18/16 with diagnoses that included but were not limited to heart failure, Alzheimer's disease, high blood pressure and age related osteoporosis. Resident #73's most recent comprehensive MDS (Minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 9/5/20. Resident #73 was coded as being severely impaired in cognitive function scoring 06 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #73 was coded as requiring total dependence on one staff member with most ADLS (activities of daily living); and supervision only with meals. Review of Resident #73 clinical record revealed she was sent to the hospital on 10/12/20 at 8:30 a.m. for poor nutrition and not easily aroused. The following note was documented: "At 08:30 AM resident lying in bed with eyes closed and breakfast tray at bedside. 118 ml (milliliters) cranberry juice with coaching and encouragement. Attempted to give resident a bite	F 842		

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F 842	Continued From page 90 of oatmeal. Residents lips puckered and sucking. Resident unable to open mouth and take food off fork. Attempted several times with biscuit and gravy and oatmeal. At 0910 resident assessed. BP (Blood Pressure) 112/54, 54 (pulse), 18 (res), 02 sats: T 98.7. Resident moaning and restless. Denies pain...Administered all other medications ordered in pudding. Coughing noted when administered. Attempted to assist resident with lunch. No intake unable to drink from straw and hard to arouse. Resident repositioned and ADL care provided. At 1400 (2 p.m.) 46 (pulse), 16 (Respirations), 99 % T (temp) 98. At 1420 Notified NP (nurse practitioner) of change in condition. Orders to send resident to ED (Emergency Department) for evaluation. Notified manager on call and (Name of RP (Responsible Party) at 1445 (2:45 p.m.) called (Name of transport). Resident left facility at 1524 (3:54 p.m.) via stretcher with (Name of transport). Sent with bed hold policy, clinical summary, face sheet, and DNR (Do not Resuscitate) Order." Review of Resident #73's September 2020 meal intake report revealed that her appetite ranged from 25 to 75 percent for all three meals. Resident #73 was coded as requiring set up help only. Further review of Resident #73's September 2020 meal intake reports revealed that Resident #73 consumed zero percent on 9/30/21 for lunch and dinner. There was no evidence that Resident #73 had consumed any meals from 9/30/20 through 10/12/20 as Resident #73's October 2020 meal intake report revealed blanks (nothing documenting) for meal intakes from 10/1/20	F 842		

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F 842	Continued From page 91 through 10/12/20, when Resident #73 was sent to the hospital. Review of Resident #73's note from the dietician directly prior to hospitalization documented the following on 9/16/20: "Current weight: 115.6 weight stable: x 30 days, -2.4 percent x 3 months. -11.1 x 6 months however suspect 3/6/20 weight to be an outlier. Resident eating 25-75 percent of meals, depending on the day, on regular diet with health shakes in place at lunch and dinner. Prostat AWC (protein), ensure enlive (supplement) BID (two times a day) and fortified foods in place to promote wound healing/skin integrity and weight stability. Notify RD (Registered Dietician) if any changes." Review of Resident #73's care plan dated 9/11/20 documented the following for ADL (Activities of Daily Living): "Encourage (Name) to feed self with use of verbal cues." Resident #73's last recorded weight prior to hospitalization was "111.60" on 10/8/20. Review of Resident #73's hospital d/c (discharge) summary dated 10/14/20 documented the following: "Admit date: 10/11/21; Hospital course: Acute Cystitis without hematuria (blood in urine), high blood pressure, Alzheimer's dementia, dehydration, moderate malnutrition...Acute cystitis without hematuria (blood in urine): IV (intravenous) Rocephin (antibiotics)- change to oral Keflex (antibiotic). Stop IV fluids. Cultures multiple bacteria. Finish course for total of 5 days...Alzheimer's Dementia with behavioral disturbance: Stepwise deterioration (meaning symptoms stay the same for a while and then suddenly get worse) daughter aware, moderate	F 842		

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F 842	Continued From page 92 malnutrition. BMI (Body Mass Index) 16..." Review of Resident #73's weight upon readmission into the facility was documented as "109.20" on 10/16/20. Review of a physician note dated 10/21/20, documented the following: "Extended conversation with daughter we planned on doing a post form but she already has one that clarifies no feeding tube but no other restrictions she is already DNR. Alzheimer's Dementia, gradually becoming worse after her last hospitalization. Anorexia, not really eating as much food daughter does not want a feeding tube and I agree...Clarified from hospital discharge notes in the hospital zone lab that her lab never indicated significant dehydration or a urinary tract infection by lab criteria. I explained that they were treating by their own judgement." The following note was documented by the physician on 10/26/20: "...Dementia is unchanged. Poor appetite is unchanged as far as solids she is drinking slightly more fluids...Spoke at length with daughter today...if she continues to not eat the daughter would speak with hospice." Review of a physician note dated 10/28/20 revealed that the daughter was allowed to visit once on 10/28/20 to make a determination if she wanted to place her mom on hospice. The following was documented in part: "Anorexia daughter was allowed in to see patient even she could only get her to drink some water. Patient seemed enthusiastic but then would stop after a certain amount and would not eat much food. No feeding tubes just encouragement. Failure to thrive: She is dwindling quickly with no oral intake	F 842		

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F 842	Continued From page 93 many discussions had over the phone with the daughter this is the first time I met her in person. - Advanced Directive: We went over a new post form. The daughter has agreed to principal to no more labs or IV's ER visits or hospitalizations. She is already DNR...Dementia is unchanged..." Review of Resident #73's October POS (Physician Order Summary) revealed an order for Hospice Services starting on 10/29/20. A note from the physician dated 11/9/20 documented in part, the following: "...When I examine her she is unable to talk it (sic) all hardly...It's getting drier by the day because memories (sic) are not moist at all anymore...currently in (sic) hospice dehydrated not eating or drinking...less responsive nonverbal today..." The following nursing note was written on 11/10/20 at 2:12 p.m.: "Responded to LPN (licensed practical nurse) reports of resident without pulse or respiration. This RN noted no audible heart rate or respiration after one full minute and pronounces TOD (Time of Death) at 2:05 p.m..." On 7/8/21 at 12:55 p.m., an interview was conducted with OSM (Other Staff Member) #8, the former dietician. OSM #8 stated that Resident #73's "normal" for meal intakes was typically 25 to 75 percent of food consumed at each meal. OSM #8 stated that Resident #73's daughter was well aware that her mother's intake varied and had varied for some time. OSM #8 stated that initially Resident #73's weights were monthly until she arrived back from the hospital and started having weekly weights until she was placed on	F 842		

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F 842	Continued From page 94 hospice on 10/29/20. OSM #8 stated that the last time she had evaluated Resident #73 prior to hospitalization was on 9/16/20 and that the resident was receiving supplements at that time. OSM #8 stated that her weight at that time was recorded at 115.60. OSM #8 stated that on 10/8/20 her weight was recorded as 111.60. OSM #8 stated that this weight loss was not significant at that time directly prior to hospitalization. When asked how she monitors Residents for appetite, weight loss; OSM #8 stated that she will ask nursing staff who frequently work with her, look at monthly or weekly weights, and also look at the meal intake reports. When asked how she would determine how a resident was eating if the meal intake reports were blank for a substantial amount of time (10/1/20 through 10/12/20); OSM #8 stated that she would look at the resident's trending weights. OSM #8 stated that Resident #73's weight loss would have been more significant if she really was not eating anything for that length of time. OSM #8 stated that she believed staff were just not documenting meals consumed. OSM #8 stated that staff were good at alerting her if there was a change in appetite or if the resident was not consuming any meals. On 7/8/21 at 1:15 p.m., an interview was conducted with CNA (Certified Nursing Assistant) #6, a CNA who worked with Resident #73 September through November 2020. CNA #6 could not remember anything regarding Resident #73 during that time. When asked the process for documenting meal intakes, CNA #6 stated that meal intakes should be documented on the ADL (Activities of Daily Living) flow sheets. CNA #6 stated that meal percentages were documented or if the resident refused meals. CNA #6 stated that the nurse is alerted with all meal refusals.	F 842		

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F 842	Continued From page 95 CNA #6 stated that she and the nurse would then try to encourage the resident to eat. CNA #6 stated that she would also alert the nurse if a resident started to decline in functional status with eating. CNA #6 stated that blanks on the ADL sheets could mean that the nursing aide forgot to document meal intakes consumed. On 7/8/21 at approximately 1:45 p.m., an interview was conducted with ASM (Administrative Staff Member) #2, the DON (Director of Nursing). ASM #2 stated that she expected nursing aides to document at each meal percentages consumed; however Resident #72's weight trends did not show any evidence of a significant decline and that staff had probably failed to document meals percentages 10/1/20 through 10/12/21. On 7/8/21 at 4:07 p.m., ASM (Administrative Staff Member) #1, the Administrator, ASM #2, the DON (Director of Nursing), and ASM #3 the corporate nurse were made aware of the above concerns. No further information was presented prior to exit. A policy could not be provided. COMPLAINT DEFICIENCY	F 842		