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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to an abbreviated survey conducted 04/20/2021 through 04/22/2021, was conducted 08/24/2021 through 08/25/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Three complaints (VA00052574 - substantiated with deficiency, VA00052285 - unsubstantiated, and VA00051727 - substantiated with deficiency), were investigated during the survey. The census in this 120 certified bed facility was 109 at the time of the survey. The survey sample consisted of 9 resident reviews	{F 000}		
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 not practicable for the development of the resident's care plan.	F 657		9/20/21

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

Electronically Signed | 09/13/2021

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F 657	Continued From page 1 (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 staff interview, clinical record review, and facility documentation review, the facility staff failed to revise the care plan in response to the changing needs for one Resident (Resident #102) in a sample size of 9 Residents. Specifically, Resident #102's care plan was not revised to reflect interventions and plan of care related to falls. The findings included: On 08/24/2021 and 08/25/2021, Resident #102's closed clinical record was reviewed. The progress notes from 03/31/2021 through 04/22/2021 included but were not limited to the following entries: An excerpt of a nurse's noted dated 03/31/2021 at 7:32 P.M. documented, "Note Text: New admit keeps sliding off of bed sitting on the floor with back against the bed." An excerpt of a nurse's note dated 04/01/2021 at 6:20 P.M. documented, "Call bell within reach. Bed in low position." A nurse's note dated 04/05/2021 at 11:14 A.M. documented, "Note Text: Resident sitting in room in chair, confused, stood up, attempted to walk, and down on knees on floor mat. No injury, no c/o	F 657	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 657 Care Plan Timing and Revision 1. Resident #2 no longer resides in Center 2. All residents are at risk for deficient practice. 100% of current patients in center with falls have had care plan and plan of care reviewed to reflect accurate current status. All deficient areas have since been corrected. 3. Staff development coordinator or designee will in-service all RN and LPN staff on need to update the Resident Plan	

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F 657	Continued From page 2 [complaints of] pain." A nurse's post fall note dated 04/06/2021 at 11:04 A.M. documented, "Situation: witnessed fall. Background: history of falls. Assessment (RN)/Appearance (LPN):LOC WNL, pain assessment, vital signs Recommendations: one on one supervision." A nurse's post fall note dated 04/06/2021 at 7:19 P.M. documented, "Late Entry: Situation: Unwitnessed Fall. Background: hx [history] of falls, weakness. Assessment (RN)[by Registered Nurse]/Appearance (LPN)[per Licensed Practical Nurse]: LOC wnl [level of consciousness within normal limits]. , VSS [vital signs stable], No pain. Recommendations: Redirection, hourly rounding, anticipate needs." An excerpt of a nurse's post fall note dated 04/09/2021 at 11:04 A.M. documented, "Recommendations: Closely monitor, frequent toilet resident as needed. Fall mats in place. Put and [sic] nurses [sic] station for better visual monitoring." A nurse's post fall note dated 04/13/2021 at 3:04 A.M. documented, "Situation: Pt. had a fall in room Background: dementia. hx [history] of falls Assessment (RN)/Appearance(LPN): skin tear to right knee Recommendations: fall mats, low bed." Resident #102's care plan was reviewed. A focus created on 04/01/2021 and revised on 04/05/2021 documented, "The resident has had an actual fall with ([sic] no injuries." Interventions associated with this focus that were created on	F 657	of care and Care plan Post fall to address interventions. 4. Staff development coordinator or designee will audit 100% of all patient falls going forward to ensure interventions are documented in Plan of care and care plan for 2 weeks, then 30% 5 times a week for 2 weeks, monthly times one month. Variances will be reviewed in quarterly QAPI meeting times one. 5. Date of compliance 9/20/2021.	

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F 657	Continued From page 3	F 657		

04/01/2021 were as follows:
"- Education regarding call for assistance
- Keep environment well lit during the day
- Resident has concave mattress."
There were no interventions discontinued or added to the care plan dated 04/05/2021 or 04/13/2021. There were no interventions related to fall mats, low bed, frequent toileting, monitoring at nurse's station, one on one supervision, or hourly rounding, as indicated in the post fall notes.

A focus created on 04/19/2021 documented, "The resident is at risk for falls r/t [related to] dementia, decreased communication, decreased balance, incontinence, and psychotropic med use."
Interventions associated with this focus created on 04/19/2021 were as follows:
"-Anticipate and meet the resident's needs.
-Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.
-Ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c [wheelchair].
-Keep environment free of trip hazards."

On 08/25/2021 at 9:20 A.M., an interview with the Director of Nursing [DON] was conducted. When asked about the interventions on the care plan related to falls, the DON stated that the expectation is that the care plan should be reviewed and revised within 24 hours of a fall. When asked if the care plan accurately represented the plan of care for [Resident #102] related to falls, the DON stated that staff documented the plan of care in their notes but not on the care plan. The DON then stated that "It doesn't paint a clear picture." At 12:15 P.M. in a

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F 657	Continued From page 4 follow-up interview, the DON stated that the nurse revised the care plan on the day of the fall as an actual fall on 04/05/2021 but did not add any interventions. The DON also stated that the interventions for fall mats and bed in low position were not on the care plan and should have been added to the care plan when they were implemented. On 08/25/2021, the facility staff provided a copy of their policy entitled, "Resident Assessment & Care Planning." Under the header, "Procedure" in Section 6, it was documented, "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment." On 08/25/2021 at 12:25 P.M., the administrator was notified of findings. By the end of survey, the administrator stated there was no further documentation or information to submit.	F 657		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review and in the course of a complaint investigation, the facility staff failed to follow professional standards of practice by failing to follow physician orders for 2 Residents (Resident #105 and #104). This	{F 658}	F 658 Services provided meet Professional Standards. 1A. Resident #105 remains in center. Medication dosage errors have been corrected and reviewed with Responsible party and medical director.	9/20/21

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{F 658}	Continued From page 5 non-compliance had the potential to cause adverse outcomes such as delay of a surgery procedure and exacerbation of clinical symptoms. The findings included: 1. For Resident #105, the facility staff failed to administer the correct dose of anti-depressant and steroid medications as ordered by a physician. On 8/24/21, a review of Resident #105's clinical record was conducted. This review revealed that Resident #105 had a physician order dated 8/19/21, that read, "Lexapro Tablet 5 MG (Escitalopram Oxalate) Give 1 tablet by mouth one time a day for depression". An order dated 1/11/21, read, "PredniSONE Tablet 5 MG Give 1 mg by mouth at bedtime for RA [rheumatoid arthritis]". On 8/24/21, a review of the MAR (medication administration record) for Resident #105 revealed the ordered Lexapro 5 mg tablet had been signed off as being administered at the 9 AM, scheduled dose on 8/24/21. Additionally, the prednisone was signed off as being given daily from 6/1/21-8/23/21, with the order for dosage being unclear. There was also evidence and signatures that a 24 hour chart check had been conducted daily. On 8/24/21 at 2:07 PM, Surveyor B talked to LPN C, who was assigned to Resident #105. Surveyor B asked LPN C to verify the Lexapro medication dose for this Resident. LPN C pulled the medication card from the medication cart and it was Lexapro 10 mg tablets. LPN C verified that	{F 658}	1B Resident # 104 no longer resides in center. 2A All current resident medication orders have been reviewed for accuracy in dosage to prevent deficient practice. All deficient areas have since been corrected. 2 B All current resident records have been reviewed to reflect accurate physician orders are in place to prevent deficient practice. All deficient areas have since been reviewed. 3. Staff development coordinator or designee will educate all RN and LPN staff on A. 5 Medication rights in order to prevent med error. B. Staff development coordinator or designee will educate all RN and LPN staff on following all physician orders. 4. A. Director of nursing or designee will audit and verify all orders related to medications to verify correct dosage being administered on 100% current residents, then 30% resident□s med orders 5 times week times 2 weeks, monthly times one month. B. Director of nursing or designee will audit 30% physician orders 5 times week for 2 weeks, 3 times a week for 2 weeks, monthly times one month, All variances will be reviewed in QAPI times one quarter 5.Date of compliance 9/20/21	

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she had given this medication to Resident #105 that morning and had given a full tablet and not broken the tablet in half. LPN C then reviewed the current physician orders for this medication and confirmed that Resident #105 was ordered to receive 5 mg, not 10 mg of Lexapro. LPN C did find in the medication cart a full card of Lexapro 5 mg tablets that was full, intact and had not been used/administered from. LPN C was asked to verify what dose of Prednisone Resident #105 was being administered. She pulled the medication from the cart and it was noted to be 1 mg tablets. LPN C read the prednisone order and said, "It says 5 mg then says give 1 mg". LPN C confirmed that the order as written was not clear and needed to be clarified.

On 8/24/21 at 2:24 PM, the DON (Director of Nursing)/Employee B accompanied Surveyor B to the unit. The DON was told of the Lexapro concern, Resident #105 had an order for 5 mg tablets and 10 mg tablets were in the cart and administered. LPN C confirmed with the DON that this was the case. LPN C showed the DON the cards of medication and stated that she had given a full 10 mg tablet that morning. The DON stated, "I talked to her daughter [Resident #105's daughter] and she doesn't want her to do the gdr [gradual dose reduction] so she is going back to 10 [10 mg] but this wouldn't be effective until later today". The DON was shown the order for the prednisone and asked to read it and advise what dose of Prednisone Resident #105 should be receiving. The DON agreed that the order was not clear and needed to be clarified.

On 8/24/21, review of the clinical record revealed multiple entries that indicated Resident #105 should have been receiving 5 mg of Prednisone.

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This dosage of 5 mg was noted in the physician progress notes dated 8/20/21, and hospital discharge summary dated 1/11/21.

On 8/25/21 at 11:08 AM, an interview was conducted with Employee E, the facility Nurse Practitioner. Employee E was notified that Resident #105's order for a decrease in dosage in Lexapro had not been carried out. Employee E confirmed she had been made aware of this. Employee E was also made aware that the dosage of Prednisone to be administered was unclear as to what milligram was to be given and again Employee E indicated she had been made aware and had given the facility staff clarification orders once notified. When asked if she expects orders to be carried out when they are given and as ordered with regards to dosage, she stated "Yes". Employee E said Resident #105 was ordered the prednisone for management of her RA and being a kidney transplant. When asked what the risks to Resident #105 was for not receiving the correct dosage of prednisone was, she [Employee E/nurse practitioner] stated, "it could be a problem but she hasn't had any worsening pain or change in her kidney function. It could have potentially been a problem but she has not had any harm from it. It got entered incorrectly and I would work her back up to that dose, I wouldn't immediately put her back on 5 mg".

2. For Resident #104, the facility staff failed to follow physician orders with regards to pre-operative instructions which included holding a blood thinner and pre-surgical decolonization techniques to reduce the risk of infection. This non-compliance resulted in Resident #104's

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surgery having to be postponed on one occasion.

On 8/24/21 and 8/25/21, a review of the entire closed electronic health record for Resident #104 was conducted. The only indication that Resident #104 had a surgery scheduled prior to 2/11/21, was a nursing note dated 12/14/20 at 11:54 AM, which read, "Away at dr [doctor] appointment". An additional note on 12/14/20 at 6:32 PM read, "medication instructions for the day of surgery the resident must take the following medications with a few sips of water only cardidopa-levdopa (Sinemet), ocular lubricant (Artificial Tears), and tramadol only if needed, but stop taking Eliquis 72 hrs. before surgery. Stop taking any NSAIDS [non-steroid anti-inflammatory drugs] 7 days before surgery. If need pain med you may take Tylenol". No date of the scheduled surgery was mentioned.

The clinical record review revealed a consultant report dated 2/4/21, that read, "surgery H&P [history and physical] today for VP [ventriculoperitoneal] shunt surgery on 2/11/21. [Surgical procedure to implant a device that relieves pressure on brain due to excess fluid and thus treat hydrocephalus]. Recommendations: 1. Stop Eliquis 3 days prior to surgery *(No Eliquis starting 2/8/21). 2. Start decolonization on 2/6/21 in AM [morning]. Chlorhexidine wash once daily (shower), Mupirocen nasal twice daily (AM & bedtime), and Chlorhexidine mouthwash (Peridex) twice daily (AM and bedtime)".

Review of the MAR (medication administration records) and physician orders revealed no indication of when the pre-operative orders, for the January surgery, were to be carried out. The MAR for February 2021, revealed that the

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Chlorhexidine wash had been entered as being a one-time occurrence ordered for 2/10/21. However, the nursing notes revealed this treatment was carried out on 2/8, 2/9, and 2/10. It was not carried out 2/6, 2/7, or 2/11. The Mupirocen nasal decolonization treatment and Chlorhexidine mouthwash were not been carried out in the morning on 2/6/21, as ordered.

On 8/25/21 at 9:41 AM, an interview was conducted with the Assistant Director of Nursing/Employee C at the nursing station. Employee C was shown a physician consultation report dated 2/4/21, that had the pre-operative instructions. Employee C read the orders, reviewed the MAR and said they were not carried out as ordered. Employee C agreed that a dose of the decolonization mouth wash and cream for the nose were missed on the first day. Employee C said the purpose of such treatments prior to surgery are to "cut down on bacteria and infections prior to surgical procedures". Employee C said the failure to follow these orders was "very concerning. I would want to know why the order wasn't put in correctly and followed". When asked if any systems are in place that should have caught the errors, Employee C said, "When we put new orders in it goes to the 24 hour report and we check them, that's our second check, then during the night shift they do a chart check, we had 3 opportunities to identify the errors".

On 8/25/21 at 10:16 AM, the DON (Director of Nursing) brought into the conference room the Resident appointment book for 2021 which revealed that Resident #104 was scheduled for surgery on 1/14/21, and a note was beside this entry that read, "rescheduled to 2/11". When asked why it was rescheduled, the DON said she

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would have to look into this.

On 8/25/21 at 11:08 AM, an interview was conducted with Employee E, the facility Nurse Practitioner. Employee E was able to recall Resident #104 and when asked about his surgery on 1/14/21, being rescheduled she stated, "He was on Eliquis [a blood thinner/anticoagulant] and I want to say it had to do with the Eliquis why he didn't get it at that time. He had a surgery scheduled to address or put a stent in for hydrocephalus, they were told to hold Eliquis, and I want to say it was not held on-time so it had to be rescheduled. I don't believe that harmed him, he came here with the hydrocephalus and the family was told to wait until after he got out of rehab for surgery and she [Resident #104 ' s spouse] wasn't happy with that response so she sought out a second opinion with [hospital system name redacted]. The next time his surgery was scheduled I put in the hold orders myself". When asked what is the process when a Resident attends an outside appointment and returns with order changes, Employee E stated, "say a patient goes on an appointment and has pre-operative orders, I sign them and they [the facility nurses] put them [the orders] in".

Employee E was asked what the purpose and risks of the "decolonization" orders prior to surgery not being carried out were. Employee E stated, "The purpose would be to prevent staph infection and MRSA so it doesn't become an infectious process. The risks of not carrying it out is infection at the surgical site". Employee E was shown the MAR for February which showed the pre-operative orders were not carried out, she stated, "I can't argue that. We were concentrating on being very diligent with this

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patient so it wouldn't happen again".

On 8/25/21 at 2:54 PM, an interview was conducted with the DON. When asked when she expected physician orders to be carried out and/or transcribed she stated, "By the end of the shift".

On 8/25/21 an interview was conducted with the Corporate Nurse Consultant, Employee F agreed that Resident #104's clinical chart/electronic health record failed to indicate that the surgical orders for the 2/11/21, had been fully carried out as ordered. She confirmed that she agreed the pre-surgical orders for Resident #104 had not been carried out on 2 separate occasions as ordered by the surgeon.

On 8/25/21 at 12:30 PM, the DON was interviewed by Surveyor B in the presence of Surveyor A. The DON confirmed that following physician orders is standard nursing practices. The DON was asked what systems are in place that should have prevented Resident #105 from getting the wrong medication doses and the orders for Resident #104 not being carried out. The DON/Employee B stated, "we do nightly chart checks and during administration she nurse should be following the 6 rights of medication administration which would have caught this".

Review of the facility policy titled, "General Dose Preparation and Medication Administration" read, "3.7 Facility staff should verify that the medication name and dose are correct...." The facility policy titled "Physicians Orders" read, "2. Upon receiving admission physician's orders from the physician, the nurse will record the order to include: a. orders- medication and treatment

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orders must include the five rights: 1. Right name of medication, 2. Right dosage, 3. Right route, 4. Right time, and 5. Include diagnosis/reason for use".

On 08/25/2021, the facility staff stated their professional nursing resource was Lippincott. According to Lippincott Nursing Procedures, Eighth Edition, Chapter 2, Standards of Care, Ethical and Legal Issues, on page 17 read, "Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders, follow appropriate nursing measures, communicate information about the patient, follow facility policy and procedures, document appropriate information in the medical record, and follow physician's orders which should not have been followed, such as orders containing medication dosage errors".

Additional Guidance from Lippincott's Nursing Center.com (www.nursingcenter.com)
"Rights of Medication Administration
1. Right patient: Check the name on the order and the patient. Use 2 identifiers. Ask patient to identify himself/herself. When available, use technology (for example, bar-code system).
2. Right medication: Check the medication label. Check the order.
3. Right dose: Check the order. Confirm appropriateness of the dose using a current drug reference. If necessary, calculate the dose and have another nurse calculate the dose as well.
4. Right route: Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route.

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{F 658}	Continued From page 13 5. Right time: heck the frequency of the ordered medication. Double-check that you are giving the ordered dose at the correct time. Confirm when the last dose was given. 6. Right documentation: Document administration AFTER giving the ordered medication. Chart the time, route, and any other specific information as necessary. For example, the site of an injection or any laboratory value or vital sign that needed to be checked before giving the drug. 7. Right reason: Confirm the rationale for the ordered medication. What is the patient's history? Why is he/she taking this medication? Revisit the reasons for long-term medication use. 8. Right response: Make sure that the drug led to the desired effect. If an antihypertensive was given, has his/her blood pressure improved? Does the patient verbalize improvement in depression while on an antidepressant? Be sure to document your monitoring of the patient and any other nursing interventions that are applicable. Reference: Nursing 2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania. Accessed online at: www.nursingcenter.com. On 8/25/21 during an end of day meeting, the facility Administrator, DON and Corporate Nurse Consultant were made aware of the facility staff's failure to follow physician orders for both Residents. No further information was provided.	{F 658}		
{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.	{F 842}		9/20/21

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{F 842}	Continued From page 14 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, 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.	{F 842}		

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{F 842}	Continued From page 15 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to maintain a complete, accurate clinical record for 3 Residents (Resident #102, Resident #105, Resident #104) in a sample size of 9 Residents. The findings included: 1. For Resident #102, there was conflicting information in the clinical record pertaining to a) falls and b) wounds.	{F 842}	F Tag 842 Resident records, identifiable information 1a Resident #102 no longer resides in center 1b Resident #104 no longer resides in center 1c. Resident #105 remains in center. Medication error has been corrected, resident receiving correct medication. The responsible party and medical director have been made aware. 2A All current residents who have had falls	

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{F 842}	Continued From page 16 On 08/24/2021 and 08/25/2021, Resident #102's progress notes from 03/31/2021 through 04/22/2021 were reviewed. There were 14 progress notes listed as post fall notes. Progress notes included but were not limited to the following entries: An excerpt of a nurse's noted dated 03/31/2021 at 7:32 P.M. documented, "Note Text: New admit keeps sliding off of bed sitting on the floor with back against the bed." A nurse's note dated 04/05/2021 at 11:14 A.M. documented, "Note Text: Resident sitting in room in chair, confused, stood up, attempted to walk, and down on knees on floor mat. No injury, no c/o [complaints of] pain." An excerpt of a nurse's communication note dated 04/05/2021 at 4:49 P.M. documented, "Note Text: spoke with 2 daughters and son of pt [patient] and gave them update about their dad and the combative behaviors and refusal of medications and falls ..." A nurse's post fall note dated 04/05/2021 at 7:04 P.M. documented, "Situation: unwitnessed fall. Background: history of falls/sliding down to the floor. Assessment (RN)[by Registered Nurse]/Appearance (LPN)[per Licensed Practical Nurse]: vital signs, pain assessment, LOC WNL [level of consciousness within normal limits]. Recommendations: one on one supervision." A nurse's post fall note dated 04/06/2021 at 3:04 A.M. documented, "Situation: post fall x2 shifts Background: pt [patient] was found kneeling beside bed on fall mats	{F 842}	in last 2 months have had care plan and Plan of care reviewed for accuracy in fall documentation. All current residents with skin integrity issues have been reviewed for accurate documentation. Deficient practice has been corrected. 2B All current resident orders have been reviewed for accuracy in MD orders related to potential delay in care are at risk. Deficient practice has been corrected. 2C All current resident medical orders have been reviewed related to correct transcription or delay in following medical orders resulting in delay of treatment. Deficient practice has been corrected. 3. Staff development coordinator of designee will provide education to all RN and LPN on A. Documentation of fall and post fall interventions in clear concise manner on plan of care and Care plan B. Correct documentation of all skin areas in medical record. C. Following MD orders to prevent delay of treatment to patient. D. Education on 5 Rights of medication administration. 4. Director of nursing or designee will audit and review A. Fall and post fall documentation on 30% patient falls 5 times a week for 2 weeks ,3 times a week for 2 weeks, monthly times one month. B. 30% of patient skin assessments for accuracy in area and treatment 5 times a week for 2 weeks, 3 times a week for 2	

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{F 842}	Continued From page 17 Assessment (RN)/Appearance (LPN): skin and pain assessments Recommendations: frequent rounding." A nurse's post fall note dated 04/06/2021 at 11:04 A.M. documented, "Situation: witnessed fall. Background: history of falls. Assessment(RN)/Appearance (LPN):LOC WNL, pain assessment, vital signs Recommendations: one on one supervision." A nurse's post fall note dated 04/06/2021 at 7:19 P.M. documented, "Late Entry: Situation: Unwitnessed Fall. Background: hx [history] of falls, weakness. Assessment (RN)[by Registered Nurse]/Appearance (LPN)[per Licensed Practical Nurse]: LOC wnl. , VSS [vital signs stable], No pain. Recommendations: Redirection, hourly rounding, anticipate needs." An excerpt of a nurse's post fall note dated 04/09/2021 at 11:04 A.M. documented, "Late Entry: Situation: post fall note. Background: History of falls, weakness, and confusion. Assessment (RN)/Appearance(LPN): Resident observed up in his wc [wheelchair] this morning. Resident denies any pain or SOB [shortness of breath]. Recommendations: Closely monitor, frequent toilet resident as needed. Fall mats in place. Put and [sic] nurses [sic] station for better visual monitoring." A nurse's post fall note dated 04/13/2021 at 3:04 A.M. documented, "Situation: Pt. had a fall in room Background: dementia. hx [history] of falls Assessment (RN)/Appearance(LPN): skin tear to right knee Recommendations: fall mats, low bed."	{F 842}	weeks, monthly for one month C. Review of all MD orders to prevent delay of treatment to patient 5 times a week for 2 weeks ,3 times a week for 2 weeks, monthly for one month. D. Director of nursing or designee will interview 30% of RN and LPN staff in 5 rights of medication ,5 times a week for 2 weeks ,3 times a week for 2 weeks, monthly for one month. All of the above will be monitored for variance in QAPI meeting times one quarter. 5.Date of compliance 9/20/21	

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On 08/25/2021 at 9:20 A.M., an interview with the Director of Nursing (DON) was conducted. When asked how many falls Resident #102 had while at the facility, the DON stated [Resident #102 had "one fall as far as I can tell." When asked if it was a witnessed fall or an unwitnessed fall, the DON stated that it was an unwitnessed fall. When asked about the protocol post-falls, the DON stated that neuro [neurological] checks should be done for 3 days following a fall and that there should be 4 post fall notes written following a fall. When asked how many post fall notes were written for [Resident #102], the DON stated, "A lot." The DON also stated that she only had one incident report related to Resident #102 having a fall. This surveyor and the DON observed the electronic incident report dated 04/05/2021. The DON stated that the risk assessment indicates it was a witnessed fall which occurred on 04/05/2021 but some of the notes document it was an unwitnessed fall so "It's very unclear."

On 08/25/2021 at approximately 2:15 P.M., a follow-up interview with the DON was conducted. When asked again about the number of falls Resident #102 had, the DON stated that she "cannot speculate" because it looks like he had "one or two" falls but "It isn't clear based on the documentation."

1b.

On 08/24/2021 and 08/25/2021, Resident #102's closed clinical record was reviewed. An electronic document entitled "Weekly Skin Assessment dated 04/14/2021 at 7:28 A.M. documented "Yes" in Section A entitled, "Observations" and subpart

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1 entitled, "Is skin intact without impairment?"

An electronic document entitled "Weekly Skin Assessment dated 04/16/2021 at 2:15 P.M. documented "No" in Section A entitled, "Observations" and subpart 1 entitled, "Is skin intact without impairment?"
Section A Subpart 4 contained the following sub-headers and selections:
Site: Right buttock
Type: Pressure
Length [centimeters]: 6
Width [centimeters]: 4
Stage: II
Section A Subpart 6 entitled, "Name of MD/NP notified: [nurse practitioner name].
Section B entitled, "Wound" Subpart 2a entitled, "Date Acquired" documented "4/16/2021."
Section B Subpart 4 documented the following selections: "Epithelial tissue present (pink). Granulation tissue present (beefy red)."
Section B Subpart 13 entitled, "Current Treatment Plan" documented, "Apply EPC [extra protection cream" once every shift and PRN [as needed]."
There was no mention of a stage 2 pressure wound to the ankle on the weekly skin assessments.

A physician's order dated 04/16/2021 documented, "Apply EPC cream to buttock/sacrum TID and PRN [three times a day and as needed]." There were no orders addressing a stage 2 pressure wound to the ankle.

The progress notes from 03/31/2021 through 04/22/2021 included but were not limited to the following entries:

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An excerpt of a nurse practitioner note dated 04/16/2021 at 2:01 P.M. documented, "Nursing staff have reported new open area to sacrum with pink healthy viable tissue at this time resident will need to be turned and repositioned. This area unavoidable due to inability to provide care, combativeness, resident refused brief changes and to be repositioned. Initially oral intake was poor but has subsequently proved somesure [sic] supplementation.

An excerpt of a nurse practitioner progress note dated 04/19/2021 at 11:49 A.M. under the header "Assessments/Plans" documented, "Pressure ulcer of unspecified ankle, stage 2 - L89.502 - EPC cream topically every 8 hours and as needed."

On 08/25/2021 at 9:20 A.M., an interview with the DON was conducted. When asked about Resident #102's wound and the treatment, the DON stated that "It looks like the nurse practitioner assessed the wound" on the sacrum and ordered EPC treatment. When asked about the standard treatment for a stage 2 wound, the DON stated that it may have been caused by moisture not pressure. The DON stated that the nurse no longer works at the facility so she cannot verify information about the wound. The DON stated that an open pressure wound would have a different treatment and a dressing ordered. This surveyor and the DON observed the nurse practitioner note dated 04/19/2021 pertaining to a stage 2 wound on the ankle. The DON stated "That's not correct." The DON also stated that it looks like "she clicked the wrong code" based on the code in the narrative note.

On 08/25/2021 at 11:35 A.M., an interview with

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Employee E, the nurse practitioner, was conducted. When asked about Resident #102's sacral wound, Employee E referred to Resident #102's clinical record and stated that "I treated a shallow open area with barrier cream." Employee E also stated that "It could've been MASD [moisture-associated skin damage]." Employee E indicated the treatment might've been different if it was a pressure wound that large [6 centimeters x 4 centimeters]. When asked if she saw the wound, Employee E stated that she could not remember whether or not she saw the wound.

On 08/25/2021 at 12:25 P.M., the administrator was notified of findings. By the end of survey, the administrator stated there was no further documentation or information to submit.

2. For Resident #105, the facility staff failed to maintain an accurate clinical record with regards to the medication the Resident was administered.

On 8/24/21, a review of Resident #105's clinical record was conducted. This review revealed that Resident #105 had a physician order dated 8/19/21, that read, "Lexapro Tablet 5 MG (Escitalopram Oxalate) Give 1 tablet by mouth one time a day for depression".

On 8/24/21 at 2:07 PM, Surveyor B talked to LPN C, who was assigned to Resident #105. Surveyor B asked LPN C to verify the Lexapro medication dose for this Resident. LPN C pulled the medication card from the medication cart and it was Lexapro 10 mg tablets. LPN C verified that she had given this medication to Resident #105 that morning and had not given a full tablet and not broken the tablet in half. LPN C then

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reviewed the current physician orders for this medication and confirmed that Resident #105 was ordered to receive 5 mg, not 10 mg of this medication [Lexapro]. LPN C did find in the medication cart a full card of Lexapro 5 mg tablets that was full, intact and had not been used/administered from.

On 8/24/21 at 2:24 PM, the DON (Director of Nursing)/Employee B accompanied Surveyor B to the unit. The DON was told of the Lexapro concern, Resident #105 had an order for 5 mg tablets and 10 mg tablets were in the cart and administered. LPN C confirmed with the DON that this was the case. LPN C showed the DON the cards of medication and stated that she had given a full 10 mg tablet that morning. The DON stated, "I talked to her daughter [Resident #105's daughter] and she doesn't want her to do the gdr [gradual dose reduction] so she is going back to 10 [10 mg] but this wouldn't be effective until later today".

On 8/25/21 at 2:54 PM, an interview was conducted with the DON/Employee B. The DON was asked if the clinical record for Resident #105 accurately reflected the medication she was administered with regards to the Lexapro dosage and she stated "No". When asked why an accurate clinical record is important she stated, "I don't know what would define accuracy, my expectations do not match the policy". She agreed that accurate documentation is nursing standards of practice and agreed that the clinical record should paint an accurate picture of what happening with the Resident.

On 8/25/21 during an end of day meeting, the facility Administrator, DON and Corporate Nurse

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Consultant were made aware of inaccurate clinical record for Resident #105.

No further information was provided.

3. For Resident #104, the facility staff failed to maintain a complete clinical record with regards to medical appointments, scheduled surgeries and reasons why surgery was rescheduled.

On 8/24/21 and 8/25/21, a review of the entire closed electronic health record for Resident #104 was conducted. They only indication that Resident #104 had a surgery scheduled prior to 2/11/21, was a nursing note dated 12/14/20 at 11:54 AM, which read, "Away at dr [doctor] appointment". An additional note on 12/14/20 at 6:32 PM read, "medication instructions for the day of surgery the resident must take the following medications with a few sips of water only cardidopa-levdopa (Sinemet), ocular lubricant (Artificial Tears), and tramadol only if needed, but stop taking Eliquis 72 hrs before surgery. Stop taking any NSAIDS [non-steroid anti-inflammatory drugs] 7 days before surgery. If need pain med you may take Tylenol". No date of the scheduled surgery was mentioned.

Review of the MAR (medication administration records) and physician orders revealed no indication of when the orders, aforementioned, were to be carried out. There was also no indication of when surgery was scheduled for, why it was postponed, etc..

On 8/25/21 at 10:16 AM, the DON (Director of Nursing) brought into the conference room the Resident appointment book for 2021 which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495266	A. BUILDING _____ B. WING _____	R-C 08/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANOVER HEALTH AND REHABILITATION CENTER	8139 LEE DAVIS ROAD MECHANICSVILLE, VA 23111

(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 842}	Continued From page 24	{F 842}		

revealed that Resident #104 was scheduled for surgery on 1/14/21, and a note was beside this entry that read, "rescheduled to 2/11". When asked why it was rescheduled, the DON said she would have to look into this.

On 8/25/21 at 11:08 AM, an interview was conducted with Employee E, the facility Nurse Practitioner. Employee E was able to recall Resident #104 and when asked about his surgery on 1/14/21, being rescheduled she stated, "He was on Eliquis [a blood thinner/anticoagulant] and I want to say it had to do with the Eliquis why he didn't get it at that time. He had a surgery scheduled to address or put a stent in for hydrocephalus, they were told to hold Eliquis, and I want to say it was not held on-time so it had to be rescheduled. I don't believe that harmed him, he came here with the hydrocephalus and the family was told to wait until after he got out of rehab for surgery and she [Resident #104 ' s spouse] wasn't happy with that response so she sought out a second opinion with [hospital system name redacted]. The next time his surgery was scheduled I put in the hold orders myself".

On 8/25/21 at 2:54 PM, an interview was conducted with the DON. When asked if she would expect the clinical record to include information about surgery dates and why surgery is rescheduled, she stated, "Yes, if I were the nurse I would expect to see a note".

On 8/25/21 an interview was conducted with the Corporate Nurse Consultant, Employee F agreed that Resident #104's clinical chart/electronic health record was incomplete.

On 8/25/21 during an end of day meeting, the

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{F 842}	Continued From page 25 facility Administrator, DON and Corporate Nurse Consultant were made aware of the interview findings with the Nurse Practitioner, who was able to recall the surgery being rescheduled due to pre-operative instructions not being followed by facility staff. No further information was provided. Complaint Deficiency.	{F 842}		