STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E075	A. BUILDING _____ B. WING _____	07/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLINE TERRACE CONV HOME	123 LAKEVIEW ROAD WOODSTOCK, VA 22664

(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 7/20/2021 through 7/22/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) was/were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/20/21 through 7/22/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 70 certified bed facility was 54 at the time of the survey. The survey sample consisted of 23 current resident reviews and 2 closed record reviews.	F 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure a complete and accurate MDS (minimum data set) assessment for four of 25 residents in the survey sample, (Residents #23, #46, #21, and #37). 1. The facility staff failed to complete the resident interview for Section C - Cognition, and Section D	F 641	**F641** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** The resident interview section for section C of the MDS has been completed/corrected for the following residents: Resident #23 Resident #46 Resident #21 Resident #37	8/15/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deanne R. Craft — TITLE: Administrator — (X6) DATE: 8/4/2021

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 641	Continued From page 1 - Mood, of the 5/24/21 MDS assessment for Resident #23. 2. The facility staff failed to complete the resident interview for Section C - Cognition of the 6/23/21 MDS assessment for Resident #46. 3. The facility staff failed to attempt the interview for Section C - Cognition for Resident #21. 4. The facility staff failed to complete the interview for Section C - Cognition of the MDS for Resident # 37. The findings include: 1. Resident #23 was admitted to the facility on 7/29/13 and had the diagnoses of but not limited to Alzheimer's, anxiety, high blood pressure, celiac disease, and COVID-19. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/24/21 coded the resident as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring supervision for eating; limited assistance for transfers and ambulation; extensive assistance for bed mobility, hygiene and toileting; total care for bathing; and was incontinent of bowel and bladder. A review of the above MDS revealed the following: Section B0700 "Makes Self Understood" was coded as "0" for "Understood" (Ability to express ideas and wants, consider both verbal and non-verbal expression: 0. Understood; 1. Usually understood - difficulty communicating some	F 641	The resident interview Section for section D of the MDS was completed/corrected for the following resident: Resident #23	8/15/21

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F 641	Continued From page 2 words or finishing thoughts but is able if prompted or given time; 2. Sometimes understood - ability is limited to making concrete requests; 3. Rarely/never understood.) Section B0800 "Ability to Understand Others" was coded as "2" for "Sometimes Understands" (Understanding verbal content, however able (with hearing aid or device if used): 0. Understands - clear comprehension; 1. Usually understands - misses some part/intent of message but comprehends most conversation; 2. Sometimes understands - responds adequately to simple, direct communication only; 3. Rarely/never understands.) This coding criteria required that the resident interview be attempted for any portion of the MDS that involves a resident interview. In Section C "Cognition" under "C0100. Should Brief Interview for Mental Status (BIMS) (C0200-C0500) be Conducted? Attempt to conduct interview with all residents" documented the following options: 0. No (resident is rarely/never understood) Skip to and complete C0700-C1000, Staff Assessment for Mental Status. 1. Yes Continue to C0200, Repetition of Three Words. Resident #23 was coded as "1" indicating the resident should have been interviewed to determine cognitive status. Further review of Section C revealed all questions were marked with a dash (-) in each box, indicating the resident interview questions were	F 641	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** MDS Coordinator will audit section C and Section D of the MDS for current residents to ensure that the resident interview for Section C and Section D of the MDS have been completed. **3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** **Social Service Director will be educated on completing the interview section of Section C and Section D of the MDS.** **MDS Coordinator will audit Section C and Section D of assessments completed (quarterly and annual) weekly x3 weeks.**	**8/27/21** 8/15/21 8/15/21

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F 641	Continued From page 3 not attempted. Instead, the section for the staff interview regarding resident cognition was completed. In Section D "Mood" under D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents." 0. No (resident is rarely/never understood) Skip to and complete D0500-D0600, Staff Assessment of Resident Mood. 1. Yes Continue to D0200, Resident Mood Interview Resident #23 was coded with a dash (-) instead of one of the above two options. In addition, all the resident interview questions in this section were also coded with a dash (-) indicating they were not attempted. Instead, the section for the staff interview regarding resident mood was completed. On 7/21/21 at 2:37 PM in an interview with RN (registered nurse) #1, the MDS nurse, when asked who completes Sections C and D of the MDS assessment, she stated that (OSM #1 - Other Staff Member), the Admissions / Social Worker, completes Sections C and D of the MDS." On 7/21/21 at 4:55 PM in an interview with OSM #1, she stated that she was not really familiar with Section B of the MDS, regarding a resident's abilities to be understood and understand others. She stated that Resident #23's conversations are not really conversations; that if you ask her a question, she doesn't necessarily answer back and is not able to make her needs known. When asked about attempting the resident interviews for	F 641	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** MDS Coordinator will report results to the QA Committee. Findings and results will be refected in the QA minutes.	9/3/21

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F 641	Continued From page 4 the MDS assessment for Section C and D, and coding it to reflect the attempt, OSM #1 stated that she was not aware there was a way to code the questions to reflect the attempt was made. She stated that she was not trained. OSM #1 stated that the previous person who completed the MDS assessment was out on maternity leave and then never returned, and she did not get the proper training to take over. There was no other documented evidence that the interviews were attempted. When asked what policies, procedures, or manuals she uses to complete the MDS assessment, OSM #1 pulled out an RAI manual for Social Services Departments, dated July 2010. This manual was outdated and did not reflect current changes to the MDS assessment requirements. On 7/22/21 at 8:16 AM an interview was conducted with RN #1. When asked if she reviews Section C and D, she stated, "Sometimes. I look over it to see the BIMS score. I don't do a great review. When she (OSM #1) first started doing them she was doing well. I glance over it. I don't go into great detail." When asked what training did she (OSM #1) have? She stated that she (OSM#1) worked with the previous social service worker on doing the MDS and was not aware of any other training. She stated, "I didn't do any training with her." When asked how long was (OSM #1) with the other social service worker for training, RN #1 stated, "About 2 weeks." When asked if 2 weeks all the training that she had, RN #1 stated, "That is correct." RN #1 further stated, "It is my responsibility to make sure the MDS is correct." When asked if two weeks is sufficient training time for the ins and outs of completing an MDS, she stated it was not.	F 641		

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F 641	Continued From page 5 According to the RAI manual (Resident Assessment Instrument) October 2019, page C-1 was documented, "SECTION C: COGNITIVE PATTERNS: Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions....Health-related Quality of Life: Most residents are able to attempt the Brief Interview for Mental Status (BIMS). A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis. Structured interviews will efficiently provide insight into the resident's current condition that will enhance good care." And on Page D-1 was documented, "SECTION D: MOOD: Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable. It is important to note that coding the presence of indicators in Section D does not automatically mean that the resident has a diagnosis of depression or other mood disorder. Assessors do not make or assign a diagnosis in Section D; they simply record the presence or absence of specific clinical mood indicators. Facility staff should recognize these indicators and consider them when developing the resident's individualized care plan. Depression can be associated with:	F 641		

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F 641	Continued From page 6 psychological and physical distress (e.g., poor adjustment to the nursing home, loss of independence, chronic illness, increased sensitivity to pain), decreased participation in therapy and activities (e.g., caused by isolation), decreased functional status (e.g., resistance to daily care, decreased desire to participate in activities of daily living [ADLs]), and poorer outcomes (e.g., decreased appetite, decreased cognitive status). Findings suggesting mood distress should lead to: -identifying causes and contributing factors for symptoms, -identifying interventions (treatment, personal support, or environmental modifications) that could address symptoms, and -ensuring resident safety." On 7/22/21 at 8:35 AM, ASM #1 (Administrative Staff Member), the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 2. Resident #46 was admitted to the facility on 12/26/08 and had the diagnoses of but not limited to aortic valve disorder, heart disease, atrial fibrillation, high blood pressure, depression, diabetes, Alzheimer's disease, COVID-19, and multiple sclerosis. The quarterly MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 6/23/21 coded the resident as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting	F 641		

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F 641	Continued From page 7 and hygiene; extensive care for dressing and transfers; supervision for eating; and was incontinent of bowel and bladder. A review of the above MDS revealed the following: Section B0700 "Makes Self Understood" was coded as "1" for "Usually Understood" (Ability to express ideas and wants, consider both verbal and non-verbal expression: 0. Understood; 1. Usually understood - difficulty communicating some words or finishing thoughts but is able if prompted or given time; 2. Sometimes understood - ability is limited to making concrete requests; 3. Rarely/never understood.) Section B0800 "Ability to Understand Others" was coded as "2" for "Sometimes Understands" (Understanding verbal content, however able (with hearing aid or device if used): 0. Understands - clear comprehension; 1. Usually understands - misses some part/intent of message but comprehends most conversation; 2. Sometimes understands - responds adequately to simple, direct communication only; 3. Rarely/never understands.) This coding criteria required that the resident interview be attempted for any portion of the MDS that involves a resident interview. In Section C "Cognition" under "C0100. Should Brief Interview for Mental Status (BIMS) (C0200-C0500) be Conducted? Attempt to conduct interview with all residents" was the following options: 0. No (resident is rarely/never understood) Skip to and complete C0700-C1000, Staff Assessment	F 641		

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F 641	Continued From page 8 for Mental Status. 1. Yes Continue to C0200, Repetition of Three Words. Resident #23 was coded as "1" indicating the resident should have been interviewed to determine cognitive status. The first question, "C0200. Repetition of Three Words" was coded as a "0" indicating the question was asked but the resident did not score any correct answers (Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: sock, blue, and bed. Now tell me the three words." Number of words repeated after first attempt. 0. None. 1. One. 2. Two. 3. Three." Section C0300. Temporal Orientation (orientation to year, month, and day) "....Ask resident: "Please tell me what year it is right now"....Ask resident: "What month are we in right now?"....Ask resident: "What day of the week is today?" was not coded as attempted to complete, as required. Further review of Section C revealed all the rest of the questions were marked with a dash (-) in each box, indicating the resident interview questions were not attempted and the resident was scored as a "99" in Section C0500 BIMS Summary Score (Add scores for questions C0200-C0400 and fill in total score (00-15). Enter 99 if the resident was unable to complete the interview.) Instead, the section for the staff interview regarding resident cognition was completed. On 7/21/21 at 2:37 PM in an interview with RN	F 641		

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F 641	Continued From page 9 (registered nurse) #1, the MDS nurse, when asked who completes Sections C and D of the MDS, she stated that (OSM #1 - Other Staff Member), the Admissions / Social Worker, completes Sections C and D of the MDS." On 7/21/21 at 4:55 PM in an interview with OSM #1, she stated that she was not really familiar with Section B of the MDS, regarding a resident's abilities to be understood and understand others. She stated that she attempted the interview with Resident #46 by completing the first question (which was properly coded) but did not complete the questions in Section C0300. OSM #1 stated that "I think I asked the year and the month, but not the day." It was noted that the MDS score was properly coded as a "99" but that the actual interview attempt did not conclude at the required point for determining whether to continue the resident interview or perform the staff interview regarding resident cognition. When asked about attempting the resident interviews for the MDS assessment and coding it to reflect the attempt, OSM #1 stated that she was not aware there was a way to code the questions to reflect the attempt was made. She stated that she was not trained. OSM #1 stated that the previous person who completed the MDS was out on maternity leave and then never returned, and she did not get proper training to take over. There was no other documented evidence that the interviews were attempted. When asked what policies, procedures, or manuals she uses to complete the MDS assessment, OSM #1 pulled out an RAI manual for Social Services Departments, dated July 2010. This manual was outdated and did not reflect current changes to the MDS assessment requirements.	F 641		

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F 641	Continued From page 10 On 7/22/21 at 8:16 AM an interview was conducted with RN #1. When asked if she reviews Section C and D, she stated, "Sometimes. I look over it to see the BIMS score. I don't do a great review. When she (OSM #1) first started doing them she was doing well. I glance over it. I don't go into great detail." When asked what training did she (OSM #1) have? She stated that she (OSM#1) worked with the previous social service worker on doing the MDS and was not aware of any other training. RN #1 stated, "I didn't do any training with her." When asked how long was (OSM #1) with the other social service worker for training, RN #1 stated, "About 2 weeks." When asked if 2 weeks all the training that she (OSM #1) had, she stated, "That is correct." She further stated, "It-is my responsibility to make sure the MDS is correct." When asked if two weeks is sufficient training time for the ins and outs of completing an MDS assessment, she stated it was not. According to the RAI manual (Resident Assessment Instrument) October 2019, Page C-5, for Section C - Cognition, was documented, "Coding Tips: On occasion, the interviewer may not be able to state the items clearly because of an accent or slurred speech. If the interviewer is unable to pronounce any cognitive items clearly, have a different staff member complete the BIMS. Nonsensical responses should be coded as zero. Rules for stopping the interview before it is complete: Stop the interview after completing (C0300C) "Day of the Week" if: 1. all responses have been nonsensical (i.e., any response that is unrelated, incomprehensible, or incoherent; not informative with respect to the	F 641		

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F 641	Continued From page 11 item being rated), OR 2. there has been no verbal or written response to any of the questions up to this point, OR 3. there has been no verbal or written response to some questions up to this point and for all others, the resident has given a nonsensical response. If the interview is stopped, do the following: 1. Code -, dash in C0400A, C0400B, and C0400C. 2. Code 99 in the summary score in C0500. 3. Code 1, yes in C0600 Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? 4. Complete the Staff Assessment for Mental Status." On 7/22/21 at 8:35 AM, ASM #1 (Administrative Staff Member), the Administrator, was made aware of the findings. No further information was provided by the end of the survey. 3. Resident # 21 was admitted to the facility on 4/29/2021 with diagnoses that included but not limited to: Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.) (1), high blood pressure, and diabetes. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment date of 5/11/202, coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. The Admission MDS assessment in Section B -	F 641		

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F 641	Continued From page 12 Hearing, Speech and Vision, coded the resident as making himself understood and sometimes understanding others. In Section C - Cognition, the question C0100 should the Brief Interview for Mental Status (BIMS) be conducted? A "Yes" was marked. The rest of the questions were marked with dashes and when viewed on the computer documented "Not assessed." An interview was conducted with RN (registered nurse) #1, the MDS coordinator, on 7212021 at 2:37 p.m. When asked who completes Section C of the MDS assessments, RN #1 stated the social worker/admissions coordinator. An interview was conducted with OSM (other staff member) #1, the social worker/admissions coordinator, on 7/21/2021 at 4:23 p.m. When asked if she completes Section C of the MDS assessments, OSM #1 stated that she did. When asked how she decides who will have an interview completed, OSM #1 stated, "I attempt it with all of them." When asked how she documents the attempts made, OSM #1 stated "If they can't answer I just document, 'not assessed." When asked how she decides which resident will complete an interview, OSM #1 stated, "I know who can't talk to me. Some of it depends on the resident and some will be a surprise. If I don't know I copy from the last one completed." The above MDS was reviewed with OSM #1, when asked if she attempted the interview with Resident #21, OSM #1 stated "I attempted it but he couldn't answer it so I marked it as not assessed." An interview was conducted with RN #1, the MDS coordinator, on 7/22/2021 at 8:16 a.m. When asked if she reviews the MDS assessments	F 641		

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F 641	Continued From page 13 before signing them off, RN #1 stated, "Sometimes I look over it to see the BIMS score. I don't do a great review." When asked if she reviews any of Section C completed by OSM #1, RN #1 stated she did when she (OSM #1) first started doing them, she was doing well. But now I just glance over them, I don't go into great detail." When asked if she had done any training with OSM #1, RN #1 stated OSM #1 had training with the previous social worker for two weeks. When asked if she provided training to OSM #1 as the MDS coordinator, RN #1 stated, she had not. When asked if it is her responsibility as the MDS coordinator to review the MDS prior to signing her name to an assessment, RN #1 stated, "It is my responsibility to make sure the MDS is correct." The above assessment was reviewed with RN #1. ASM (administrative staff member) #1, the administrator, was made aware of the above concern on 7/22/2021 at 9:15 a.m. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26. 4. Resident #37 was admitted to the facility on 9/22/2017 and a recent readmission, 1/9/2019, with diagnoses that included but were not limited to: stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1), aphasia (Inability to speak or express oneself in	F 641		

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F 641	Continued From page 14 writing or to comprehend spoken or written language because of a brain disorder.) (2) and diabetes. The most recent MDS assessment, an annual assessment, with an assessment reference date (ARD) of 6/13/2021, coded the resident as having both short and long term memory difficulties and was coded as being severely impaired to make daily cognitive decisions. The admission MDS assessment, in Section B - Hearing, Speech, and Vision, coded the resident as usually making himself understood and usually understands others. In Section C - Cognition, a dash, was documented and not assessed, under the question, should the brief interview for mental status be conducted. The rest of the questions were marked with dashes and when viewed on the computer it documented "Not assessed." 7/21/2021 at 4:23 p.m. When asked if she completes Section C of the MDS assessments, OSM #1 stated that she did. When asked how she decides who will have an interview completed, OSM #1 stated, "I attempt it with all of them." When asked how she documents the attempts made, OSM #1 stated "If they can't answer I just document, 'not assessed." When asked how she decides which resident will complete an interview, OSM #1 stated, "I know who can't talk to me. Some of it depends on the resident and some will be a surprise. If I don't know I copy from the last one completed." The above MDS was reviewed with OSM #1. OSM #1 stated she did the assessment above and did not attempt the interview. OSM #1 stated the resident only says, "No."	F 641		

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F 641	Continued From page 15 Two other assessments, a quarterly assessment, with an ARD of 3/14/2021 and a quarterly assessment with an ARD of 12/20/2020, were coded in Section C as the annual assessment above. These two assessments were reviewed with OSM #1. OSM #1 stated she did not attempt the interview on these two assessments. An interview was conducted with RN #1, the MDS coordinator, on 7/22/2021 at 8:16 a.m. When asked if she reviews the MDS assessments before signing them off, RN #1 stated, "Sometimes I look over it to see the BIMS score. I don't do a great review." When asked if she reviews any of Section C completed by OSM #1, RN #1 stated she did when she (OSM #1) first started doing them, she was doing well. But now I just glance over them, I don't go into great detail." When asked if she had done any training with OSM #1, RN #1 stated OSM #1 had training with the previous social worker for two weeks. When asked if she provided training to OSM #1 as the MDS coordinator, RN #1 stated, she had not. When asked if it is her responsibility as the MDS coordinator to review the MDS prior to signing her name to an assessment, RN #1 stated, "It is my responsibility to make sure the MDS is correct." The above assessment was reviewed with RN #1. ASM (administrative staff member) #1, the administrator, was made aware of the above concern on 7/22/2021 at 9:15 a.m. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and	F 641		

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F 641	Continued From page 16 Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 44.	F 641		
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) 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, clinical record review, facility document review and staff	F 657	**F657** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** Resident #44's comprehensive care plan was revised to include the resident's participation in his pain management program in choosing between multiple ordered as needed pain medications.	8/15/21

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F 657	Continued From page 17 interview, it was determined facility staff failed to revise the comprehensive care plan for one of 25 residents in the survey sample, Resident #44. The facility staff failed to revise the comprehensive care plan of Resident #44 to include the resident's participation in their pain management program in choosing between multiple ordered as needed pain medications. The findings include: Resident #44 was admitted to the facility with diagnoses that included but were not limited to atrial fibrillation (1), gout (2), and osteoarthritis (3). Resident #44's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/22/2021, coded Resident #44 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Section J coded Resident #44 as receiving as needed pain medications and non-medication interventions for pain. Section J further coded Resident #44 as having pain frequently. On 7/20/2021 at approximately 3:35 p.m., an interview was conducted with Resident #44. When asked about his pain management, Resident #44 stated that his pain was controlled fairly well. Resident #44 stated that the nurses assessed his pain by asking what number the pain was on a numerical scale. Resident #44 stated that he had been managing his pain prior to admission and would ask for the specific pain medication he wanted to take when he felt that he needed it. Resident #44 stated that the nurses attempted non-pharmacological interventions prior to administering the medications each time.	F 657	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or Designee will audit the medical record of Residents with physician's orders for as needed pain medications to ensure that the comprehensive care plan appropriately reflects the residents right to participate in their pain management program as indicated. **3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON/Designee will educate MDS Coordinator on revising the comprehensive care related to PRN pain medication.	9/1/21 9/1/21

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F 657	Continued From page 18 Resident #44 stated that he took Tylenol sometimes for his pain but he had stronger medications ordered also if he needed them. The facility "clinical resident profile" documented Resident #44 as their own responsible party. The physician orders for Resident #44 documented in part, - "Order Date: 6/23/2021 Lidoderm Patch 5 % (five percent) (Lidocaine) Apply to shoulder topically every 12 hours as needed for shoulder pain./patch on for 12 hours off for 12 hours..." - "Order Date: 4/7/2021 Tylenol Tablet 325 MG [milligram] (Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for pain, headache or fever greater than 100..." - "Order Date: 6/23/2021 oxyCODONE HCl [hydrochloride] Tablet 5 MG (milligram) *Controlled Drug* Give 1 (one) tablet by mouth every 8 (eight) hours as needed for Pain..." - "Order Date: 6/23/2021 Naproxen Tablet 500 MG Give 1 tablet by mouth every 12 hours as needed for gout symptoms..." - "Order Date: 4/27/2021 Patient requesting Naproxen to be scheduled every 12 hours instead of prn (as needed) however he has a history of GI (gastro-intestinal) bleed so will urge him to use prn only for now." The comprehensive care plan for Resident #44 documented in part, "The resident is at risk for pain r/t (related to) chronic back and shoulder pain, impaired mobility, gout. Date Initiated: 04/21/2021. Revision on: 06/03/2021." The comprehensive care plan failed to evidence documentation of Resident #44 participating in his pain management program by advising the nursing staff which as needed pain medication he	F 657	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON/Designee will audit new orders for PRN pain medication weekly x3 weeks to ensure that they have been care planned appropriately. DON and/or designee will report results to the QA committee. Findings and results will be reflected in the QA minutes.	09/1/21 9/3/21

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F 657	Continued From page 19 wanted when he complained of pain. The "Pain Evaluation" for Resident #44 dated 6/18/2021 documented in part, "...Chronic back and shoulder pain...How does the resident express and/or communicate pain? Select all that apply." The evaluation documented the following selected, "1. Negative verbalizations: groaning, crying, whimpering, screaming, etc." and "No pain reported." The evaluation further documented that Resident #44 did not have any conditions that would impede their communication of pain. The progress notes for Resident #44 documented in part, - "5/26/2021 08:30 (8:30 a.m.) ...Complaining of pain "all over" both the joints and the muscles, particularly upper legs and upper arms. He says it's awful, and neither tramadol nor APAP (pain medication) are helping much...Assessment and Plan: 1. Myalgia/myositis (pain/inflammation of muscles) - multiple- Sounding like ESR (erythrocyte sedimentation rate) or other rheumatologic issue. Will obtain CRP (C - reactive protein test), ESR (erythrocyte sedimentation rate), CCP (cyclic citrullinated peptide), RF (rheumatoid factor) and CPK (creatinine phosphokinase). 2. Gout- Just in case this may be related to increased furosemide (diuretic medication), will increase allopurinol (gout medication) as below..." - "6/22/2021 09:30 (9:30 a.m.) ...He has bilateral shoulder and knee pain for which he is taking oxycodone but feels the dose is inadequate... Assessment and Plan: ...2. Bilateral shoulder joint pain- Poorly controlled pain. Pain worse with left shoulder with history of rotator cuff surgery. Will add acetaminophen 650 mg to be taken with	F 657		

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F 657	Continued From page 20 oxycodone 5mg. Will evaluate response..." - "6/25/2021 08:55 (8:55 a.m.) ... [Resident #44] is personally involved in his care and is in communication with family members and friends on a regular basis..." - "7/1/2021 12:33 (12:33 p.m.) ...Resident is alert and oriented with clear speech. Minimal difficulty hearing but does not wear hearing aids. Understood and understands. History of cataracts with implants. Wears reading glasses. Feeds self after tray setup. Uses cane for ambulation. Supervision to limited assistance with ADLs (activities of daily living). Continent of bowel and bladder. Currently on PT/OT (physical therapy/occupational therapy) caseload for strengthening and mobility, to promote independence with ADLs [activity of daily living], and decrease fall risk. Pleasant and cooperative with care. Resident sits in recliner in room off and on through the day. He is noted with a history of chronic back and shoulder pain. Receives prn (as needed) medications with effect. Previously discussed with staff need for scheduled pain meds to which he declined..." - "7/5/2021 06:20 (6:20 a.m.) Note Text: Discussed increase in need for pain medications since admission to facility. Resident gave several reasons for pain from anticoagulants, poor kidney function similar to dialysis patients, bed/mattress and inability to sleep. During discussion resident was asked if he was using oxy (oxycodone) to help him sleep or d/t (due to) pain. He stated "maybe a little bit of both". Resident also stated "I am not a drug seeker, I am 80 years old." This writer redirected resident to the need to find out why pain has increased so that the root of the pain could be addressed. Resident in agreement to begin with environmental factors such as the bed/mattress."	F 657		

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F 657	Continued From page 21 - "7/8/2021 10:54 (10:54 a.m.) Note Text: Care Plan Meeting: Resident ambulated with cane with steady gait to meeting. Reviewed current status. Resident states he feels a lot better since Pradaxa (anticoagulant) was discontinued. Stated he is not having pain in joints or burning. He also stated the ulcers in mouth have resolved. Resident aware of possible change [sic] of stroke. Stated that he has been sleeping at night since mattress was changed. Resident has been noted bumping toes on clean out trap in room. No social service issues noted at this time. Resident stated the food is better. Resident encouraged to notify staff of any issues so that they may be addressed as they occur. Spoke highly of food, personnel and atmosphere at facility. Participates in activities. Therapy states resident is independent in mobility and care. Resident was discharged d/t (due to) reaching max potential. Resident very thankful to be at facility. Care Plan reviewed and interventions up to date. Will continue with current plan of care at this time. Offered and resident declined copy of care plan at this time." On 7/21/2021 at approximately 2:02 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the care plan communicates what was needed for resident care. LPN #1 stated nurses could review residents' care plans but the MDS (minimum data set) coordinator communicated care plan changes. LPN #1 stated that when a resident had multiple as needed pain medications ordered they tried the lowest ordered pain medication first. LPN #1 stated that they attempted Tylenol prior to administering anything stronger. LPN #1 stated that Resident #44 was their own responsible party, alert and oriented and participated in their pain management by asking for the pain	F 657		

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F 657	Continued From page 22 medication that he felt he needed at that time. LPN #1 stated that the physician and the resident worked together to manage his pain. On 7/21/2021 at approximately 2:50 p.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that Resident #44 participated in their pain management program and requested the specific pain medication they wanted when they were in pain. ASM #2 stated that the nurses were aware that Resident #44 asked for the medication he wanted when he had pain and reported this to the next shift. ASM #2 stated that they had provided Resident #44 with a new mattress which had helped with some of the pain. ASM #2 stated that the care plan should reflect the fact that Resident #44 made the choice for which as needed pain medication he received for his pain. ASM #2 reviewed Resident #44's care plan and stated that there was no specific documentation regarding Resident #44 participating in their pain management by choosing which as needed pain medication they preferred to be administered for their pain. On 7/21/2021 at approximately 3:50 p.m., an interview was conducted with RN (registered nurse) #1, the MDS coordinator. RN #1 stated that they reviewed progress notes, looked at physician orders and reviewed risk management documents daily to determine when a care plan needed updating or revising. RN #1 stated that the care plan provided an overall picture of the care that they should be providing to the resident based on their specific needs. RN #1 stated that Resident #44's ability to choose which as needed pain medication he was administered should be included on the care plan.	F 657		

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F 657	Continued From page 23 On 7/21/2021 at approximately 10:09 a.m., ASM (administrative staff member) #1, the administrator stated that they used their policies and procedures as their standard of practice. On 7/21/2021 at approximately 4:45 p.m., a request was made to ASM #1, the administrator for the facility policy for revising the care plan. On 7/22/2021 at approximately 8:30 a.m., ASM #1 provided the policy, "Care Plan Policy." The facility policy, "Care Plan Policy" documented in part, "Nursing care plans are arranged into three parts which includes Care Plan Problem, Care Plan Goal, and Care Plan Interventions which should be utilized to provide individualized care according to the needs of the residents at [Name of Facility]..." The facility policy, "Pain Management" documented in part, "...Pain management will be a collaborative effort between the resident, physician, and representatives of the interdisciplinary team including but not limited to: pharmacy, nursing, mental health professionals, rehab [rehabilitation] therapy, social services, etc..." According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient	F 657		

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F 657	Continued From page 24 and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." On 7/21/2021 at approximately 4:35 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Atrial fibrillation A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html>. 2. Gout A type of arthritis. It occurs when uric acid builds up in blood and causes inflammation in the joints This information was obtained from the website: https://medlineplus.gov/ency/article/000422.htm. 3. Osteoarthiris- Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658	**F658** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?**	

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F 658	Continued From page 25 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for one of 25 residents in the survey sample, Resident #21. The facility staff to clarify physician orders for two as needed pain medications prescribed for Resident #21 without parameters to determine when and which medication to administer. The findings include: Resident # 21 was admitted to the facility on 4/29/2021 with diagnoses that included but not limited to: Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.) (1), high blood pressure, and diabetes. The most recent MDS (minimum data set), an admission assessment, with an assessment date of 5/11/202, coded the resident as having both short and long term memory difficulties and being severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent of one or more staff members for all of his activities of daily living. In Section J - Health Conditions, coded the resident as having no pain during the look back period. Resident #21 was coded as not receiving any scheduled or as needed pain medications. The physician orders dated, 4/29/2021,	F 658	Physician' s orders for as needed pain medications have been clarified to include parameters that determine when and which medication to administer for Resident #21. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or designee will audit the medical record of residents with multiple PRN pain medications to ensure that parameters are established to determine when and which medication to administer.	**9/1/21** 8/25/21

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F 658	Continued From page 26 documented, "Acetaminophen Tablet (Tylenol - used to treat mild to moderate pain) (2) 325 mg (milligrams) give 2 tablet by mouth every 6 hours as needed for pain/fever greater than 100. Hydrocodone - Acetaminophen Tablet 5 - 325 mg (5 mg of Hydrocodone and 325 mg of Acetaminophen)(used to treat moderate to severe pain) (3) give 1 tablet by mouth every 4 hours as needed for pain, maximum dose is 6 tablets in 24 hours." Review of the May 2021 MAR (medication administration record) for Resident #21 documented the above physician orders for pain medications. The Acetaminophen was not administered in May. The Hydrocodone-Acetaminophen was administered on 5/21/2021 at 11:17 p.m. for a pain level of "8." The June MAR for Resident #21 documented the above physician orders for pain medications. The Acetaminophen was administered once on 6/15/2021 at 1:18 a.m. for a pain level of "5." The Hydrocodone -Acetaminophen was administered on 6/5/2021 at 1:16 p.m. for a pain level of "6", on 6/10/2021 at 12:26 a.m. for a pain level of "7", and on 6/17/2021 at 8:00 p.m. for a pain level of "7." The July 2021 MAR for Resident #21 documented the above physician orders for pain medications. The Acetaminophen was not administered during the month of July. The Hydrocodone -Acetaminophen was administered on 7/9/2021 at 5:44 a.m. for a pain level of "8" and on 7/14/2021 at 1:00 a.m. for a pain level of "5." The comprehensive care plan dated 6/8/2021,	F 658	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON and/or designee will educate licensed nurses on clarifying physician's orders to include parameters for Residents with multiple PRN pain medications. **4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON and/or Designee will audit the medical record of residents with more than one prn pain medication weekly x3 weeks to ensure that parameters are in place.	9/1/21 9/1/21

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F 658	Continued From page 27 documented in part, "Focus: (Resident #21) has potential for pain r/t (related to) history of trauma to penis d/t (due to) catheter, impaired mobility, history of pain, spinal stenosis and history of ocular pain." The "Interventions" documented in part, "Administer analgesia per orders. Give 1/2 hour before treatments or care as indicated." The most recent "Pain Evaluation" dated 6/28/2021 documented in part, the resident had a history of pain. He was on scheduled pain medication regimen. He had received PRN (as needed) pain medication. "6. Ask resident: 'Have you had pain or hurting at any time in the last 5 days?" A mark was made next to, "not assessed," "7. Ask resident: 'How much of the time have you experienced pain or hurting over the last 5 days?" A mark was made next to, "not assessed," "8. Ask resident : Over the past 5 days, has pain made it hard for your to sleep at night?" A mark was made next to, "not assessed," "9. Ask resident: 'Over the past 5 days, have you limited your day-to-day activities because of pain?" A mark was made next to, "not assessed," The form further documented the resident had no pain reported. and the resident had cognitive impairments. "Is the resident currently communicating pain?" A mark was made next to "No." "If the resident is unable to verbalize pain, evaluated using the face pain scale." A mark was made under the face for "No Hurt." An interview was conducted with LPN (licensed practical nurse) #1 on 7/21/2021 at 2:03 p.m. When asked how staff know which as needed pain medication to administer if a resident has two as needed pain medication orders without any parameters, LPN #1 stated she would start with the Tylenol, try the lowest form of	F 658	DON and or Designee will report results to the QA committee. Findings and results will be reflected in the QA minutes.	9/1/21

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medications first, see if the Tylenol works. I would also take into account what their pain level is as well. When asked if deciding which medication to give, if that is in her scope of practice, LPN #1 stated, "Yes, if there are no parameters." The above orders were reviewed with LPN #1. LPN #1 stated, "I would try the Tylenol first but I think we need some sort of parameters in there."

An interview was conducted with ASM (administrative staff member) #2, the director of nursing, on 7/21/2021 at 2:54 p.m. ASM #2 reviewed the pain medication orders above. ASM #2 stated, "He came from a facility where they had him on scheduled Tylenol. He had a penile lesion and the scheduled Tylenol was for that pain in his penis. Before he came to us, he was on hospice care and they (hospice) had him on the Hydrocodone. He came in here with those orders. He was used to getting the Hydrocodone." When asked if the resident was on hospice at this facility and if he still had the penile lesion, ASM #2 stated he was no longer on hospice and the penile lesion had healed. When asked when the lesion healed, ASM #2 stated she would need to find out. ASM #2 stated when she gave report to the staff upon his arrival as she had evaluated him at the other facility, she told them he had been receiving the Hydrocodone as PRN (as needed) and the Tylenol was ineffective for the pain of the lesion. The staff automatically went to the hydrocodone. When asked how staff determine which as needed pain medication to administer when there are no parameters, ASM #2 stated the nurse needs to assess the pain, if he complains it extravagant they go to the Hydrocodone. When asked if it's in the nurse's scope of practice to decide which one to give,

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F 658	Continued From page 29 ASM #2 stated, "No, it's not. The order does not say anything about if Tylenol ineffective, or pain scale, the nurse judgment comes into play when the nurse does the assessment. His pain is sporadic, the Tylenol wasn't effective. ASM #2 was asked again when the penile lesion healed, ASM #2 stated, "I believe it's a month ago after he was here." ASM #1, the administrator, stated on 7/21/2021 at 10:09 a.m. the facility follows their policy and procedures as their standard of practice. On 7/21/2021 at approximately 3:30 p.m. ASM #2 presented a nurse's note dated, 5/29/2021 at 6:45 a.m. that documented in part, "Weekly Wound Rounding completed 5/29/2021. The resident's urethra/penis skin impairment has healed." The facility policy, "Pain Management" documented in part, "Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals...2. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential for pain. b. Effectively recognizing the presence of pain. c. Identifying the characteristics of pain. d. Developing and implementing approaches to pain management. f. Identifying and using specific strategies for different levels and sources of pain. g. Monitoring for the effectiveness of interventions. h. Modifying approaches as necessary...5 b. If pain symptoms have resolved or there is no longer an indication for pain medication, the multidisciplinary team and physician shall try to discontinue or taper analgesic medications to the	F 658		

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F 658	Continued From page 30 extent possible...7. The physician and staff in collaboration with the resident/resident's representative will establish a treatment regimen based on consideration of the following: a. The resident's medical condition, b. Current medication regimen, c. Nature, severity and cause of the pain, d. Course of the illness and, e. Treatment goals." According to "Lippincott Manual Of Nursing Practice", Eighth Edition: by Lippincott Williams & Wilkins, pg. 87 read: "Nursing Alert: Unusual dosages or unfamiliar drugs should always be confirmed with the health care provider and pharmacist before administration." On pg. 15, the following is documented in part, "Inappropriate Orders: 2. Although you cannot automatically follow an order you think is unsafe, you cannot just ignore a medical order, either. b. .. Call the attending physician, discuss your concerns with him, obtain appropriate..orders. c. Notify all involved medical and nursing personnel.... d. Document clearly." ASM #1 and ASM #2 were made aware of the above findings on 7/21/2021 at 4:35 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601006.h	F 658		

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F 658	Continued From page 31 tml	F 658		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758	**F758** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** PRN psychotropic medication (Ativan) for Resident #25 was discontinued on 7/20/21. PRN psychotropic medication (Seroquel) for Resident #12 was reviewed by the Physician with recommendation and justification for medication documented on 7/28/21.	7/20/21 7/28/21

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F 758	Continued From page 32 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to ensure two of 25 residents were free of unnecessary psychotropic medications, Resident #12 and Resident #25. 1. The facility staff failed to reassess Resident #12 for continued use of an as needed antipsychotic medication 14 days after it was ordered on 6/23/2021. 2. The facility staff failed to ensure the physician or nurse practitioner documented their rationale for and indicated the duration of use for Resident #25's prescribed as needed lorazepam (1) ordered on 5/17/21 and discontinued on 7/20/21. The findings include: 1. Resident #12 was admitted to the facility with diagnoses that included but were not limited to schizophrenia (1), anxiety disorder (2) and dementia (3). Resident #12's most recent MDS (minimum data set) assessment, a quarterly assessment with an	F 758	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** DON and/or designee will complete an audit of all PRN psychotropic medications to ensure that residents have been reassessed for continued use of as needed psychotropic medications within 14 days of order date. Proper documentation of assessment will be maintained.	8/15/21

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F 758	Continued From page 33 ARD (assessment reference date) of 5/3/2021, coded Resident #12, as scoring a 2 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 2- being severely impaired for making daily decisions. Section E coded Resident #12 as displaying verbal behavioral symptoms directed towards others 4 to 6 days but less than daily. Section N coded Resident #12 as receiving antipsychotic and antianxiety medications. Section N further coded Resident #12 as receiving antipsychotics on a routine basis only with a gradual dose reduction attempted on 3/3/2021. The comprehensive care plan for Resident #12 documented in part, "[Name of Resident #12] is on psychotropic medication use r/t (related to) a diagnosis of schizophrenia. Date Initiated: 08/23/2016. Revision on: 03/08/2021." The physician's orders for Resident #12 documented the following in part, - "Order Date 6/9/2021 QUEtiapine Fumarate (antipsychotic medication) Tablet 25 MG (milligram) Give 1 (one) tablet by mouth every 24 hours as needed for agitated behavior due to dementia. May give once a day at any time in addition to scheduled doses --this is a permanent order and should not be discontinued." - "Order Date: 6/23/2021 QUEtiapine Fumarate Tablet 25 MG Give 1 tablet by mouth every 24 hours as needed for agitated behavior due to dementia. May give once a day at any time in addition to scheduled doses --this is a permanent order and should not be discontinued." The eMAR (electronic medication administration record) for Resident #12 dated "6/1/2021-6/30/2021" documented Resident #12	F 758	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** DON and/or designee will audit PRN psychotropic medications weekly x3 weeks to ensure that residents are reassessed for use of PRN psychotropic medications within 14 days of the order date. Proper documentation will be maintained of assessment. **4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** DON will report results to the QA committee. Findings and results will be reflected in the QA minutes	9/1/21 9/3/21

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F 758	Continued From page 34 received Quetiapine Fumarate 25mg by mouth every 24 hours as needed on 6/13/2021 at 8:53 p.m. and 6/27/2021 at 1:50 p.m. The eMAR for Resident #12 dated 7/1/2021-7/31/2021" documented Resident #12 received Quetiapine Fumarate 25mg by mouth every 24 hours as needed on 7/9/2021 at 2:56 p.m., 7/11/2021 at 11:28 a.m., and 7/12/2021 at 1:39 p.m. The physician progress notes documented Resident #12 was last assessed by the physician on 6/23/2021. The progress notes further documented Resident #12 was last assessed by the nurse practitioner on 5/25/2021 and the psychiatrist on 5/25/2021. The "Consultant Pharmacist's Medication Regimen Review" for Resident #12 dated 7/15/2021 documented in part, "Note: (No response required.) This resident has a current PRN (as needed) order for Quetiapine 25mg tablets, 1 Q24H (every 24 hours) as needed for agitated behavior due to dementia with no stop date indicated in the MAR (medication administration record). PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. To be compliant with CMS (Centers for Medicare and Medicaid services) 483.45(e)(5) please ensure the proper documentation is made in the resident's medical record..." The "Physician/Prescriber Response" section of the document contained the following response from the provider, "Disagree, chronic persistent schizophrenia. Managed by [Name of	F 758		

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F 758	Continued From page 35 psychiatrist], psychiatry. 7/20/21" On 7/21/2021 at approximately 1:49 p.m., an interview was conducted with ASM (administrative staff member) #5, medical doctor. ASM #5 stated that Resident #12 was treated with the as needed Quetiapine for behaviors related to the schizophrenia. ASM #5 stated that Resident #12 was also under the care of the psychiatrist and was previously on higher dosages of the medication in the past. ASM #5 stated that the pharmacy had advised them that they could only order the medication for 14 days and they were not sure if it was a pharmacy rule or a state rule but Resident #12 required the medication when they exhibited the behaviors like agitation and screaming out. ASM #5 stated that they assessed Resident #12 monthly, performed a full assessment and documented it in the progress notes. ASM #5 stated that they had last assessed Resident #12 on 6/23/2021. ASM #5 stated that Resident #12 had not been assessed in July yet. On 7/21/2021 at approximately 10:09 a.m., ASM (administrative staff member) #1, the administrator stated that they used their policies and procedures as their standard of practice. The facility policy, "Psychoactive Medication Policy" documented in part, "Purpose: To provide the residents of [Name of Facility] the appropriate medications at the therapeutic dosage to promote the best quality of life, while treating conditions as indicated. Procedure: Residents will receive psychoactive medications, as ordered, when necessary to treat conditions or diagnosis..." On 7/21/2021 at approximately 4:35 p.m., ASM	F 758		

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F 758	Continued From page 36 #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: 1. Schizophrenia "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information is taken from the website https://medlineplus.gov/schizophrenia.html 2. Anxiety Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary. 3. Dementia A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. 2. Resident #25 was admitted to the facility on 8/14/03. Resident #25's diagnoses included but were not limited to delusional disorder, diabetes and mild intellectual disabilities. Resident #25's quarterly minimum data set assessment with an assessment reference date of 5/24/21, coded the resident's cognition as severely impaired. A note signed by ASM (administrative staff	F 758		

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F 758	Continued From page 37 member) #3 (nurse practitioner) on 5/18/21 documented, "89 year old male with history of schizophrenia (2)...Dementia: BIMS (brief interview for mental status) score 4 (out of 15). Noted increased agitation, yelling, swinging arms, seeing 'ghosts' for past 6 weeks. Assessment and Plan. 1. Dementia with behavioral disturbance- With history of schizophrenia. Start low dose olanzapine (3) with plan to increase dosing as needed to control agitation. Lorazepam 0.5 mg (milligrams) prn (as needed) agitation..." A physician's order dated 5/17/21 documented an order for lorazepam 0.5 mg- one tablet by mouth every six hours as needed for agitation. Resident #25's comprehensive care plan, revised on 5/18/21 documented, "(Resident #25) has been placed on psychotropic medications due to dx (diagnosis) of delusions, agitation, behaviors and psychological symptoms. Resident is know (sic) to be yelling out at call bells and has been throwing things (his clock and radio) in his room. He will say that 'the ghost' will break his clock or throw his cup. Administer PSYCHOTROPIC medications as ordered by physician..." The care plan failed to document specific information regarding as needed lorazepam. Review of Resident #25's May 2021 and June 2021 MARs (medication administration records) revealed the resident was administered as needed lorazepam on 5/18/21, 5/21/21, 6/1/21, 6/4/21, 6/11/21, 6/12/21 and 6/13/21. Further review of Resident #25's clinical record failed to reveal any physician or nurse practitioner documentation regarding lorazepam until 6/16/21.	F 758		

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F 758	Continued From page 38 A note signed by ASM #3 on 6/16/21 documented, "(Resident #25) has developed some agitated and oppositional behaviors in the past 6 months. He claims he is seeing ghosts, and the ghost talks to him and tells him to do things. He becomes obstreperous (difficult to control) when he wants his snack or a soda or coffee, and his requests are not met immediately. Sertraline (4) was started in April, which has had no effect on his delusions or agitation. Olanzapine was started at 2.5 mg last month, but did not have any impact on his claims of seeing ghosts; yesterday it was increased to 5mg. Lorazepam PRN (as needed) was started 5/17, which does seem to settle him somewhat. Assessment and Plan. 1. Restlessness and agitation- It is not clear to me that (Resident #25) is actually having hallucinations, or whether these claims of ghosts telling him to break things may be a ploy for attention. He does tend to ask for snacks and sodas and coffee a lot. I doubt that the psychotropics he is on will make much difference in these behaviors, but will give them a chance..." The note failed to document the rationale or indicate the duration for the extended use of the as needed lorazepam. Review of Resident #25's July 2021 MAR revealed the resident was administered as needed lorazepam on 7/19/21 and the medication was ineffective. Further review of Resident #25's clinical record failed to reveal any physician or nurse practitioner documentation regarding lorazepam until 7/20/21. A note signed by the nurse practitioner on 7/20/21 documented Resident #25's lorazepam was discontinued due to non-use.	F 758		

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F 758	Continued From page 39 On 7/21/21 at 1:31 p.m., a telephone interview was conducted with ASM #3. ASM #3 stated Resident #25 was a gentleman who did not have a formal psychotic disorder but had been extremely agitation, throwing things and cursing. ASM #3 stated she prescribed scheduled olanzapine but it takes time for that medication to build to a therapeutic level so she prescribed as needed lorazepam as a backup in case Resident #25 became extremely agitated. ASM #3 stated she continued to see that Resident #25 presented with episodes of agitation in notes so she increased the olanzapine and wanted to continue the lorazepam while titrating the olanzapine. The olanzapine was increased on 6/22/21. ASM #3 stated she sees Resident #25 once a month and documents a monthly note. When asked if she documented the rationale or planned duration for the continued use of the lorazepam, ASM #3 stated she was not sure and could do a better job. ASM #3 stated she discontinued the lorazepam on 7/20/21 because it was not being used. On 7/21/21 at 4:41 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Psychoactive Medication Policy" failed to document specific information regarding the use of as needed anti-anxiety medication. No further information was presented prior to exit. References: (1) Lorazepam is used to relieve anxiety. This information was obtained from the website:	F 758		

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F 758	Continued From page 40 https://medlineplus.gov/druginfo/meds/a682053.html (2) "Schizophrenia is a serious brain illness. People who have it may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. The disorder makes it hard for them to keep a job or take care of themselves." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=schizophrenia&_ga=2.199297134.1149227542.1626906426-916836440.1626906426 (3) Olanzapine is used to treat schizophrenia. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601213.html (4) Sertraline is used to treat depression. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697048.html	F 758		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812	**F812** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?**	

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F 812	Continued From page 41 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to store food in accordance with standards for food service safety. Observation during the facility task- kitchen observation on 7/20/21 at 11:30 AM, revealed an open 16 ounce bag of Lays Wavy potato chips with an expiration date of 7/13/21 and an opened 26 ounce canister of fajita seasoning with an expiration date of 5/31/21 The findings include: On 7/20/21 at 11:30 AM, an observation was conducted in the main kitchen. In the dry storage room a 26 ounce canister of fajita seasoning was opened on 7/14/19 with an expiration date of 5/31/21. The fajita canister was 20% full. A 16 ounce bag of Lays Wavy potato chips were opened and dated as 7/8/21-7/10/21. The manufacturer expiration date on the bag of chips was 7/13/21. The Lays Wavy chip bag was 33% full. An interview was conducted on 7/20/21 at 12:00 PM with OSM (other staff member) #5, the assistant dietary manager. When asked to review the fajita seasoning canister and the Lays	F 812	Potato chips with an expiration date of 7/13/21 and fajita seasoning with an expiration date of 5/31/21 were disposed of on 7/20/21. **2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** CDM will conduct an inspection of the dry storage area to ensure that items are not expired. **3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** CDM will educate dietary staff that dry storage area is to be inspected weekly for expired items.	7/20/21 8/10/21 8/15/21

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F 812	Continued From page 42 potato chip bag, OSM #5 stated, "They should have been thrown out. We keep the seasonings we use the most above the stove and go through them quickly. The chips were expired on 7/13/21 and should have been thrown away." The ASM (administrative staff member) #1, the administrator, was made aware of the finding on 7/20/21 at 1:05 PM. On 7/21/21 at 10:09 AM, when asked what standard of practice you follow, ASM #1 stated, "We follow our own policies and procedures." The facility's "Dry Storage" policy was provided on 7/21/21 at 12:05 PM, documents in part, "Following inspection of delivered goods, place newly delivered items behind the older stock to ensure that the older products are used first: adhere to 'First In, First Out (FIFO)'. Check stock moved to front, and discard any items that are at or beyond expiration date." No further information was provided prior to exit.	F 812	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** CDM and/or designee will inspect the dry storage area weekly x3 weeks to ensure that there are no expired items and compliance is maintained. CDM will report results to the QA committee. Findings and results will be reflected in the QA minutes	9/3/21
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.	F 842	**F842** **1. How will corrective action be accomplished for those residents found to be affected by the deficient practice?** .Resident #31's February 2021 MRR was removed from the miscellaneous tab in Resident #47 EMR.	8/1/21

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F 842	Continued From page 43 §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. §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	F 842	The facility placed a late entry within the EMR with the details of Resident #46's fall (details as recorded on the facility incident report). The inappropriate resident name was removed from Resident #21's comprehensive care plan.	8/15/21 8/15/21

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F 842	Continued From page 44 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 observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide a complete and accurate medical record for three of 25 residents in the survey sample, Resident #47, Resident #46 and Resident #21. 1. The facility staff failed to ensure a complete and accurate medical record to include the medication regimen review (MRR) for Resident #47. Resident #31's February 2021 MRR was under the miscellaneous tab in Resident #47's EMR (electronic medical record). 2. The facility failed to ensure a complete an accurate medical record for Resident #46. The details of Resident #46's fall on 5/20/21 were not documented in the clinical record. 3. The facility staff failed to ensure another resident's name was not on Resident #21's comprehensive care plan.	F 842	**2. How will the facility identify other residents having the potential to be affected by the same deficient practice?** 1. ADON will audit the miscellaneous tab of the residents EMR for misfiled items. 2. DON and/or designee will review nurses notes related to falls within the past 7 days to ensure that appropriate documentation of the fall is documented within the EMR. 3. DON and/or designee will review resident care plans completed within the last 7 days to ensure that the appropriate name is on /within the care plan.	8/1/21 **9/1/21** **9/1/21**

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F 842	Continued From page 45 The findings include: 1. Resident #47 was admitted to the facility on 2/25/16. Resident #47's diagnoses included but were not limited to: dementia (progressive state of mental decline) (1), Alzheimer's (progressive loss of mental ability and function often accompanied by personality changes and emotional instability) (2), subarachnoid hemorrhage (loss of large amount of blood into the space beneath the dura matter) (3) and osteoarthritis (arthritis with degenerative joint changes) (4). Resident #47's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 6/28/21, coded the resident as scoring 09 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. MDS Section G- Functional Status: coded the resident as total dependence for transfers, bathing, dressing, and toileting; extensive assistance with bed mobility, and personal hygiene. Resident #47 was coded as requiring supervision for eating/locomotion and walking did not occurring. A review of MDS Section H- bowel and bladder coded the resident as always incontinent for bowel and for bladder. A review of Resident #47's comprehensive care plan dated 5/25/16 revised 9/25/19, documented in part, "FOCUS-Potential for discomfort, injury, impaired safety: at risk for adverse drug reaction related to high number of medications. Discuss with resident if able and family the number and type of medications she is taking and the potential for drug interactions and side effects from over-medication.	F 842	**3. What measures will be put into place or systemic changes made to ensure the deficient practice will not reoccur?** 1. ADON will be educated to ensure that Medication review regimens are scanned to the appropriate resident EMR. 2. DON and/or designee will educate licensed nurses on documenting falls within the Resident's EMR. 3. MDS Coordinator will be educated to ensure that Resident name is documented appropriately within the comprehensive care plan.	8/10/21 8/10/21 8/10/21

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F 842	Continued From page 46 INTERVENTIONS-Discuss with the resident if able and family the number and type of medications she is taking and the potential for drug interactions and side effects from over medication. Request physician to review and evaluate medications. Review pharmacy consult recommendations and follow up as indicated." A review of Resident #47's EMR (electronic medical record) revealed monthly MRR's (medication regimen review) from August 2020 through July 2021. In the month of February 2021, there were two "Recommendations for February" documents. One was for Resident #47 and the second was for Resident #31. Resident #31 was admitted to the facility on 1/30/17. Resident #31's diagnoses included but were not limited to: dementia (progressive state of mental decline) (1), Parkinson's (slowly progressive neurological disorder characterized by tremors) (5), transient ischemic attack (brief episode of insufficient blood to the brain) (6) and fibromyalgia (chronic pain condition with widespread musculoskeletal aching) (7). Resident #31's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 6/1/21, coded the as scoring 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of Resident #31's comprehensive care plan dated 1/30/17, which documents in part, "FOCUS-Potential for discomfort, injury, impaired safety: at risk for adverse drug reaction related to high number of medications. INTERVENTIONS-Discuss with the resident if able and family the number and type of	F 842	**4. How does the facility plan to monitor it's performance to make sure that the solutions are sustained?** ADON will complete 2 medical record reviews weekly x3 weeks to monitor for complete and accurate electronic medical records to include the following: MRR in appropriate record Correct resident names within the comprehensive care plan. Proper documentation of falls within the nurses notes. QA committee. Findings and results will be reflected in the QA minutes.	9/1/21 **9/3/21**

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F 842	Continued From page 47	F 842		

medications she is taking and the potential for drug interactions and side effects from over medication. Request physician to review and evaluate medications. Review pharmacy consult recommendations and follow up as indicated."

An interview was conducted on 7/21/21 at 12:50 PM with ASM (administrative staff member) #2, the director of nursing. When asked who is responsible for scanning documents into the EMR, ASM #2 stated, "That is the ADON (assistant director of nursing)."

An interview was conducted on 7/21/21 at 12:55 PM with ASM #4, the assistant director of nursing. When asked if she is responsible for scanning documents specifically the MRR into the EMR, ASM #4 stated, "Yes, I am." ASM #4 was asked to review Resident #47's EMR, and the two MRR in February 2021, one for Resident #47 and the second one for Resident #31. ASM #4 stated, "The names are so close together, I must have inadvertently scanned them together. I will remove Resident #31's MRR." Review of Residents #47's EMR at 1:30 PM revealed that Resident #31's MRR was no longer filed in Resident #47's EMR chart.

ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above concern on 7/21/21 at 4:36 PM.

On 7/21/21 at 10:09 AM, ASM #1 stated, "The standard of practice is our policies and procedures."

According to facility's policy and procedure titled "Clinical Record" dated 4/16/18, which documents the following, "Clinical records are

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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 842	Continued From page 48 maintained on each resident in accordance with federal and state regulations and within accepted professional standards and practices. The clinical record shall be accurate, complete, and present organized clinical information about each resident in a manner that is readily accessible for resident care." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 25. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 547,266. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 420. (5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 420. (6) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 576. (7) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 223. 2. Resident #46 was admitted to the facility on 12/26/08 and had the diagnoses of but not limited to aortic valve disorder, heart disease, atrial fibrillation, high blood pressure, depression, diabetes, Alzheimer's disease, COVID-19, and multiple sclerosis. The quarterly MDS (Minimum	F 842		

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	49E075	A. BUILDING _____ B. WING _____	07/22/2021

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F 842	Continued From page 49 Data Set) assessment, with an ARD (Assessment Reference Date) of 6/23/21 coded the resident as being severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing, toileting and hygiene; extensive care for dressing and transfers; supervision for eating; and was coded as incontinent of bowel and bladder. A review of the clinical record revealed the following: A nurse's note dated 5/20/21 at 7:09 PM documented, "Spoke with (name of RP - responsible party) regarding (Resident #46) fall earlier this evening. Advised (RP) that (Resident #46) is not complaining of any pain, and there is no injury. Will continue to monitor with neuro [neurological] checks." A nurse's note dated 5/21/20 at 8:37 AM documented, "(Resident #46) noted with areas of discoloration this morning from fall. Area to her right wrist purple in color size 2.5 cm (centimeters) x 1.5 cm and discoloration Dark Purple in color to left elbow area size 4cm x 4.5cm. POA (Power of Attorney) called informed discolored areas." A nurse's note dated 5/21/20 at 8:47 AM documented, "5-21-2021 @ (at) 0630 (6:30 AM) --Resident continues on neuro checks, done @ 2330 (11:30 PM), 0130 (1:30 AM), and 0530 (5:30 AM). Last set of vitals @ 0530 were 118/62-64-17-97.3 temporal--SAT 96% r/a (blood pressure - pulse - respirations - temperature via temporal reading - oxygen saturation 96% on room air). No c/o (complaints of) pain voiced. Will monitor areas of discoloration located on the	F 842		

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F 842	Continued From page 50 Right wrist and Left elbow." There were no notes that documented the details of the fall itself - when, where, how, situation, etc. A review of the fall investigation report dated 5/20/21 at 7:11 PM documented at the bottom of each page, "Privileged and Confidential - Not part of the Medical Record." This form documented, "Incident Description: I was advised by CNA (Certified Nursing Assistant) that (Resident #46) had fallen OOB (out of bed). On arrival to room resident was on the floor with legs still on the bed. (Resident #46) was immediately assessed (Neuros (neurological checks), Pain, and Fall Assessment). She is alert but confused Resident apparently rolled out of bed to floor. The resident is able to move all extremities well and is asymptomatic of any obvious pain or discomfort. Once the assessment was completed, the resident was assisted back to her bed with the use of the Hoyer lift and 3 staff members. (Resident #46) noted with areas of discoloration to her right wrist area purple in color size 2.5 cm x 1.5 cm and discoloration to left elbow area size 4cm x 4.5 cm. Resident advised that "wind blew her out of the bed." Denied trying to get oob." "Immediate Action Taken: Assessment completed. Bed in lowest position, call light within reach. Educated the staff to position straight in bed when head of bed is elevated to prevent her from leaning over and falling. Roll booster applied to bed. Fall mat placed on floor by the bed. MD (Medical Doctor) and POA notified. Continue all interventions as ordered and reevaluate as indicated."	F 842		

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F 842	Continued From page 51 This form further documented that the physician and the RP (POA) were notified on 5/20/21 at 7:15 PM. The above details on this form about the circumstances of the fall were not documented in the clinical record. On 7/22/21 at 8:35 Am, an interview was conducted with ASM #1 (Administrative Staff Member, the Administrator). She stated the nurse who was present at the time of the fall and completed the incident report no longer worked at the facility. When asked if the incident report is part of the legal clinical record, ASM #1 stated it was not. She reviewed the nurse's notes in the record and agreed that documentation on the incident report regarding the details of the fall were not documented in the clinical record and should have been. A review of the facility policy, "Clinical Records" documented, "....The clinical record shall be accurate, complete, and present organized clinical information about each resident in a manner that is readily accessible for resident care....The clinical record will contain an accurate and functional representation of the actual experience of the resident in the facility...." On 7/22/21 at 8:35 AM, ASM #, was made aware of the findings. No further information was provided by the end of the survey. 3. Resident # 21 was admitted to the facility on 4/29/2021 with diagnoses that included but not limited to: Alzheimer's disease, high blood pressure, and diabetes.	F 842		

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F 842	Continued From page 52 The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment date of 5/11/202, coded the resident as having both short and long term memory difficulties and as severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent of one or more staff members for all of his activities of daily living. In Section J - Health Conditions, coded Resident # 21 as having no pain during the look back period. Resident #21 was coded as not receiving any scheduled or as needed pain medications. The comprehensive care plan dated, 6/8/2021, documented in part, "Focus: (Another Resident's name) has Diabetes Mellitus." An interview was conducted with RN (registered nurse) #1, on 7/21/2021 at 1:43 p.m. When asked if another resident's name should be on a resident's care plan, RN #1 stated, "No." The care plan above was reviewed with RN #1. RN #1 stated she did it, it was her that incorrectly documented another resident's name. When asked if that is an accurate clinical record, RN #1 stated, "No," ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above finding on 7/21/2021 at 4:35 p.m. No further information was provided prior to exit.	F 842		