STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495303	A. BUILDING _____ B. WING _____	C 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE RIVERS HEALTH & REHAB CENTER	2960 CHELSEA ROAD WEST POINT, VA 23181

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/27/21 through 07/29/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/27/21 through 07/29/21. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints, (VA00051885-substantiated with deficiency and VA00051936-substantiated without deficiency), were investigated during the survey. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 22 resident reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		9/1/21

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

Electronically Signed | 08/20/2021

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on Resident and Staff interview, clinical record review and facility documentation the facility staff failed to treat Residents with respect and dignity for 1 Resident (#28) in a survey sample of 22 Residents. For Resident # 28 the facility staff undressed the Resident wrapped her in a sheet, put her in the shower chair and wheeled her down the hall to wait in line for a shower causing Resident to state "it feels like punishment."	F 550	1.) Residents #28 was assessed and interviewed by nursing staff and interviewed by social services. The resident and provider were notified of bathing patterns and schedule. The resident□s plan of care was reviewed and updated to reflect their resident-specific needs. 2.) Nursing staff performed assessment and interview with residents and recorded results in medical record. Nursing has	

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F 550	Continued From page 2 The findings included: Resident number 28, an 86 year old woman admitted to the facility on 8/8/17, with diagnoses of but not limited to anemia, hypertension, hypothyroidism, Rheumatoid arthritis and major depressive disorder. Resident #28's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/7/21, coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 10. Section G coded this resident as (3) extensive assistance with one person physical assist for bed mobility, (4) total dependence for transfers requiring two persons or more physical assistance and the use of mechanical lift, she is coded as (3) extensive assistance one person physical assistance for dressing, she is independent with set up help only for meals, she is coded as (4) total dependent for toileting, and bathing. G0400 functional limitations in range of motion (A) upper extremity impairment on both sides (B) lower extremity coded as to impairment on both sides G0600 mobility devices (C) wheelchair. For walking she is coded as (8) activity did not occur. She is unable to stand or bear weight. She can self-propel with her wheel chair for mobility and is coded as independent for locomotion on and off the unit with the wheelchair. On 7/27/21 at 2:30 PM a Resident Council meeting was held and Resident #28 attended. Resident # 28 was oriented to person, place, time, and situation and she actively participated in the meeting. Resident #28 asked the question "Why do I have to have a cat and dog fight to get a shower?" When asked about her shower	F 550	notified residents, responsible parties and provider of bathing patterns and schedule for residents. Nursing staff has ensured that care plan interventions are appropriate and address resident specific care needs. 3.) The Director of Nursing/designee has educated clinical staff, including RNs, LPNs, CNA□s and NAs regarding shower schedule, documentation, residents□ rights and dignity. The education includes, but is not limited to, the importance of showers and regular bathing, documentation, resident rights and dignity, and reporting any concerns or refusals to supervisor. 4.) The Director of Nursing/designee will review ADL documentation and nurses notes five times weekly for six weeks to ensure that showers are being provided to residents as scheduled, and documentation is complete. The Director of Nursing/designee will perform daily rounds for six weeks to ensure that residents rights and dignity are being maintained during bathing. The Social Services Director will perform random interviews with residents twice daily for six weeks to ensure that residents are satisfied that their individual bathing needs are being met. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and provide education as needed on an ongoing basis. Findings will	

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F 550	Continued From page 3	F 550		

experience she stated that is was "horrible." She stated she knew she had the right to get 2 showers a week but she felt she had to fight to get them. She also stated the staff come to her room with the shower chair and undress her, wrap her in a sheet, then push her down the hall in the shower chair dressed only in a sheet. She stated "Sometimes there is a line and I have to wait in the hallway dressed like that until the other person in the shower is finished" When asked how that made her feel she "Why do they punish us like that? That's what it feels like punishment."

Resident #28 was asked if she knew why they weren't giving her showers and had she asked that question to staff. Resident #28 and the other simultaneously stated "They are Short Staffed." When asked how she knew that they were short staffed she stated, "The CNA's tell you, I can't give you a shower we don't have enough staff."

A review of the Resident Council Minutes reflect that the slow call bell response times have been mentioned in February 2021, March 2021, April 2021, May 2021, and June 2021.

Resident #28 stated "When you ring the bell usually someone will come in and say I will be back. They cut off the light and never come back." Resident #28 and Resident # 47 stated they have waited sitting on the bedpan or toilet for up to an hour waiting for staff to return. She also made the comment "They should not treat us this way, it just ain't right."

On 7/28/21 at approximately 8:45 AM a review of the POC (Point of Care- computer system where the CNA's chart the ADL care for the Residents),

be discussed with the QAPI committee on at least a quarterly basis.

5.) Date of Compliance: 9/1/2021

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F 550	Continued From page 4	F 550		

revealed the following:

Resident #28 - Received 0 Showers - 23 Partial Baths - 3 Bed Baths

07/28/21 11:10 AM Interview conducted with CNA A (an agency CNA) who was asked how she knew which Residents were to get showers that day. CNA A stated they told me that there is a shower list at the nurse's station. She was asked to describe the process of giving a shower to a Resident. She said "We go to the room and bring the shower chair, depending on the resident sometimes we use a lift or sit to stand lift and some can transfer with a little assistance. We get them undressed and wrap them in a sheet and take them to the shower room in the shower chair. We bring their toiletries and clean clothes with us. The shower aid will then shower them and get them dressed."

07/28/21 11:16 AM an interview was conducted with CNA's B and C (agency staff - CNA's assigned as "Shower Aids") CNA C stated she has been working at the facility for few weeks through agency and states "This is the first time I have seen 2 shower aides on one shift, and in general this much staff. Since you all came in yesterday there has been plenty of staff."

CNA C was asked if there has been times that showers were not given due to lack of sufficient staffing and she stated that it has happened a lot but they do give the Residents a partial bath instead if they cannot get the showers done. CNA B was asked if she has seen times that there was line of Residents waiting in the hall to get in the shower, she stated, "Yes it's happened a few times since I have been here."

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F 550	Continued From page 5 07/28/21 10:09 AM, interview was conducted with the Administrator who was asked if there were issues with staffing at the facility, she said "At times yes." She was then asked if it impacted the care of the Residents, she said "It may put a delay on things like call bell responses." When asked if there were any resident complaints of care due to short staffing she answered, "No complaints but they have made the comments about having to wait longer for care." On 7/29/21 approximately 10:00 AM the Administrator submitted a statement in writing about the steps taken to ensure timely call bell answering. The statement read as follows: "CALL BELL RESPONSE TIMES" "Actions taken to mitigate extended call bell response times" "-Monitoring call bells daily." "-Reviewing and making staff aware of the averages and extended wait times" "-Staff are aware that call bells are to remain on until task has started" "-Discussion with staff during huddles regarding response times" "-Document average response times on huddle board (When the system is functioning properly)" On 7/29/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 550		
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to	F 574		9/1/21

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F 574	Continued From page 6	F 574		

receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:
(i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes -
(A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;
(B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act.
(C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and
(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.
(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State

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F 574	Continued From page 7 Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility record review the faculty staff failed to provide Residents with a written description of legal rights which includes the names and addresses and phone numbers of State Office of Licensure and Certification, LTC agencies and Ombudsman. The findings included: For the 10 of the 10 Residents attending Resident Council on 7/27/21 at 2:30 PM the facility staff have not verbally told them and have not given	F 574	1.) Three Rivers Health & Rehab Center has determined that all residents have the potential to be affected by this deficient practice. During Resident Council in August 2021, process for filing and reporting grievances, contact information for the Ombudsman and State Office of Licensure and Certification was reviewed with attendees. 2.) Three Rivers Health & Rehab Center has updated its admission packet to	

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F 574	Continued From page 8 them in writing a list of the agencies with which they may file a formal complaint. On 7/27/21 during the Resident Council meeting 10 of the 10 Residents that attended, (including the Resident Council President), stated they did not know how to file a grievance, and they did not know they could file a formal complaint with the Ombudsman, and they did not know they could file a complaint with the State Office of Licensure and Certification. Only 1 Resident out of 10 Residents in attendance knew that the Survey Results were available in the lobby area. On 7/28/21 a review of the new admission packet revealed that there was a document in the packet that outlined the information on grievance procedures, complaints to the State and Ombudsman. The document gave the correct information phone numbers and addresses and was to be signed by the Resident or RP upon admission to the facility. Surveyor C could not locate the signed copy within any of the clinical records of those that attended the Resident Council meeting... 0n 7/28/21 at 12:30 PM an interview was conducted with Employee G who stated that since the change in ownership in February 2021 the facility has limited access to the Resident records prior to February 2021, because they are on the other company's website which "only 4 people were given access to and 2 of those no longer work here." On 7/29/21 during the end of day meeting the concerns were expressed to the Administrator and no further information was provided.	F 574	address filing and reporting grievances and has included contact information for the ombudsman and state OLC in he admission packet. Information on the grievance process, as well as contact information for the ombudsman and state OLC, has been mailed or hand-delivered to current residents and/or their resident representatives. 3.) The Administrator/designee has educated the admissions coordinator on the importance of providing grievance process information and ombudsman/state OLC contact information to residents and/or resident representatives upon admission. Resident education has been addressed in the August 2021 resident council meeting. 4.) The Administrator/designee will review all admissions weekly for 6 weeks to ensure that information was provided to resident and/or responsible party and that a signed copy or copy of certified letter was placed in record. Any issues identified will be addressed immediately by the Administrator/designee and appropriate actions will be taken. The Administrator/designee will identify any trends and/or patterns identify any additional education and training and provide additional education on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	

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F 580	Continued From page 9	F 580		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		9/1/21

§483.10(g)(14) Notification of Changes.
(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and

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F 580	Continued From page 10 phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to notify the responsible party of a change of condition for 1 Resident (Resident #13) in a sample size of 22 Residents. The findings included: 1) For Resident #13, the facility staff failed to notify the responsible party regarding: a) a procedure performed on Resident #13 by the podiatrist on 07/30/2020. b) the discovery of a right heel wound on 09/02/2020. Resident #13, a 76-year old male, was admitted to the facility on 05/23/2019. Diagnoses for Resident #13 included but were not limited to diabetes mellitus, dementia, and aphasia. Resident #13's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/10/2021 was coded as an annual assessment. The Brief Interview for Mental Status was not assessed.	F 580	1.) Resident #13 was assessed by nursing staff and medical record reviewed. The resident□s responsible party and provider have all been notified and updated on all changes in conditions and new orders up to date. The resident□s plan of care was reviewed and updated to reflect their resident-specific needs. 2.) The Director of Nursing/designee has audited resident clinical documentation for the past 30 days to ensure residents and or resident representatives have been notified of clinical changes. Any variances were addressed and residents and/or resident representatives were notified and the notification was documented in the medical record. 3.) The Director of Nursing/designee has in-serviced clinical nursing staff, including RN□s and LPN□s, and interdisciplinary team members regarding notification of responsible party of all changes in	

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F 580	Continued From page 11 On 07/28/2021 at approximately 5:30 P.M., in the course of a complaint investigation, documentation concerning an abscess around the time of July 2020 was requested. On 07/28/2021, the nursing progress notes from 04/27/2020 through 10/13/2020 of Resident #13's clinical record were reviewed. There was no documentation addressing an abscess or an abscess being drained. There was no documentation the responsible party was notified regarding any change in condition on 07/30/2020. On 07/29/2021 at approximately 9:00 A.M., the facility nurse consultant provided a copy of a podiatrists' progress note dated 07/30/2020. The nurse consultant stated that Resident #13 did not have an abscess but it was perhaps "an ingrown toenail treated by a podiatrist." Under the sub-header entitled, "Chief Complaint" an excerpt documented, "The patient was seen by request of the nursing facility. The facility also gives consent to treat this patient this date." Under the header entitled, "Plan" an excerpt documented, "A sterile tissue Nipper was used to perform the incision and drainage, removing the ingrowing nail spicule, granulation tissue, and draining tissue engorgement with clear fluid." A nursing progress note dated 09/03/2020 at 6:29 P.M. documented, "Late entry for 9/2/2020: Approached by CNA that resident had a wound to his right heel. Upon inspection, interior right heel has open wound approximately 3.5cm x 3.5cm x 0.1 cm. It has blood present. Cleaned it and received order to cover it with foam dressing. Also covering left heel as preventative per order." The note did not include the notification of the responsible party.	F 580	condition and new orders and to document notification in medical record. The in-service includes, but is not limited to, the importance of notifications of changes in condition, room moves, new orders, incidents, as well as the importance of documenting notifications in the medial record. 4.) The Director of Nursing/designee will review all progress notes and new orders five times weekly for six weeks to ensure that notifications are being completed and documented appropriately. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	

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F 580	Continued From page 12 On 07/28/2021 at 3:10 P.M., the Director of Nursing (DON) was interviewed. When asked about the expectation for staff if there is a change in condition regarding skin assessments, the DON stated it is expected that the family would be notified. On 07/29/2021 at approximately 12:15 P.M., the administrator and DON were notified of findings. Documentation to support that the family was notified of the new wound identified on 09/02/2020 or the podiatry procedure on 07/30/2021 was requested. By the end of survey, no documentation was received and the administrator stated there was no further documentation to submit.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each	F 582		9/1/21

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F 582	Continued From page 13 resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed to complete a SNF ABN (Skilled Nursing Facility Advance Beneficiary Notice) for 1 Resident (Resident #27) in a survey sample of 3	F 582	1.) Resident #27 is currently a long-term care resident and it is not appropriate to provide an ABN at this time. Education has been provided to the Social Services Director and Director of Therapy on	

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F 582	Continued From page 14 Residents reviewed for Beneficiary Notifications. For Resident #27, the facility staff failed to provide a SNF ABN notice prior to skilled care services ending. As a result of this deficient practice Resident #27 was not afforded the opportunity to continue skilled care services and have Medicare make a determination about coverage of such services, known as a demand bill. The findings included: Resident #27, was admitted to the facility on 3/22/21, with a readmission date of 5/1/21. Resident #27's diagnoses included but were not limited to: Severe Hyperkalemia, Acute Kidney Injury Stage III, and UTI (urinary tract infection). Resident #27's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 5/6/21 was coded as an admission assessment. Resident #27 was coded as having had a BIMS (brief interview for mental status) score of 13, which indicated no cognitive impairment. The resident was also coded as requiring extensive assistance of staff members for activities of daily living (ADL's) to include transfers, dressing and toileting. Resident #27 was discharged from a Medicare covered Part A stay on 5/22/21, she remained in the facility. The facility staff provided the survey team the Medicare discharge notices submitted to Resident #22 on 7/28/21 at 11:44 AM. Review of these documents revealed the facility staff issued a NOMNC (notice of Medicare non-coverage) and Resident #27 signed receipt	F 582	proper process for issuing the SNF ABN on 7/30/2021. Three Rivers Health and Rehab Center has identified that all Medicare A residents are at risk from not receiving an ABN. 2.) Administrator/designee audited all skilled discharges since 8/1/21 to ensure that the ABN was issued appropriately. No other concerns were identified. 3.) The Administrator/designee has in-serviced the Director of Therapy and Social Services Director regarding SNF ABNs and policy and procedure. The in-service includes, but not limited to, the facility to provide a SNF ABN information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. 4.) The Administrator/designee will meet with Director of Therapy and Social Services Director weekly for 6 weeks to review all previous weeks SNF discharges from therapy services to ensure a SNF ABN was issued prior to discharge of services and documentation of such is completed appropriately. Any issues identified will be addressed immediately by the Administrator/designee and appropriate actions will be taken. The Administrator/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.	

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F 582	Continued From page 15 of the document on 5/19/21. Facility Staff provided no evidence of an ABN being issued. On 07/29/21 at 11:20 AM, an interview was conducted with the facility Administrator. The Administrator was asked about the notices issued to Resident #27 and she stated, "It was not issued, it was forgotten. We didn't have a Social Worker so therapy was handling it and only knew of the NOMNC. It is an opportunity for education for sure". Review of the facility policy titled, "Medicare ABN-Advance Beneficiary Notice Policy" read, "ABN- A written notice you must issue to a Fee-For-Service beneficiary before furnishing items or services that are usually covered by Medicare but are not expected to be paid in a specific instance for certain reasons, such as lack of medical necessity". CMS identifies when the ABN is required to be issued in their document titled "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)" read, "Medicare requires SNFs to issue the SNFABN to Original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: "Not medically reasonable and necessary; or "Considered custodial". "The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.	F 582	5.) Date of Compliance: 9/1/2021	

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F 582	Continued From page 16 SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS-R-131 when applicable for Medicare Part B items and services". Accessed online at: https://www.cms.gov/search/cms?keys=ABN The Administrator was informed on 7/29/21 at 11:30 AM, of the failure of facility staff to provide Resident #27 with a SNF ABN notice prior to skilled care services ending, which would have allowed Resident #27, to make a decision about continuation of services and have Medicare make the coverage determination. The facility Administration team, to include the Administrator and Director of Nursing were again notified on 7/29/21 at 12:30 PM, of the lack of appropriate notice being issued to Resident #27. No further information was provided prior to survey exit.	F 582		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		9/1/21

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F 607	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to implement their abuse policy regarding the screening of employees for 4 employees (CNA F, CNA G, LPN C, and RN B) in a sample of 25 employee records reviewed. CNA F, CNA LPN C faild to sign their sworn statements timely, or completely. RN B did not have reference checks. The findings included: On 7/28/21, a review of a sample of 25 of the facility's employee files was conducted by Surveyor E. The reviews revealed the following: 1. CNA F's hire date was confirmed as 8/10/20. CNA F signed a sworn statement on 1/23/2021. Therefore, CNA F had not "sworn" to not having any convictions or pending charges of barrier crimes from 8/10/20-1/23/21, prior to being permitted to provide direct care to Residents. In addition, on the sworn statement signed 1/23/21, CNA F failed to answer questions 2 and 3. These questions asked if he/she had "Ever been convicted of a law violation(s) but excluding offenses committed before your eighteenth birthday that were finally adjudicated in a juvenile court or under a youth offender law? Are you the subject of any pending criminal charges"? 2. CNA G's hire date was confirmed as 3/4/21. CNA G signed a sworn statement on 5/19/2021. Therefore, CNA G was permitted to work directly	F 607	1. Complete sworn statements have been obtained for the 3 employees and the reference check was completed for 1 employee identified in the 2567. Copies are on file in the facility for all 4 employees identified in the 2567. 2. An audit has been completed on all current employee files to ensure a sworn statement has been obtained and all questions were answered as well as reference checks were completed on all potential employees. No further issues were identified. 3. The Human Resources Director/Designee will verify that all potential employees fully complete a sworn statement and reference checks are completed prior to employment. Completed forms will be kept on file and available in the facility. 4. The Human Resources Director/Designee will review the files of all potential employees to ensure that sworn statements and reference checks are completed prior to any potential employee starts work at Three Rivers Health & Rehab Center. An employee file audit form has been developed to include the reference checks and sworn statement form. The audit form will be completed prior to new employees being allowed to work in the facility. The Human Resources Director/Designee will review the audit forms monthly for completion to	

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F 607	Continued From page 18 with Residents within the facility without having "sworn" to not having any convictions or pending charges of barrier crimes. CNA G's reference checks prior to hire were blank and not obtained. 3. LPN C's hire date was confirmed as 5/18/21. LPN C signed a sworn statement on 5/10/2021. However, LPN C failed to answer question 2. This question asked if he/she had "Ever been convicted of a law violation(s) but excluding offenses committed before your eighteenth birthday that were finally adjudicated in a juvenile court or under a youth offender law? 4. RN B's hire date was confirmed as 5/5/21. Review of RN B's reference checks revealed they were blank and had not been obtained prior to hire. On 7/28/21 at 4:06 PM, Surveyor E met with Employee J, the Human Resources Coordinator and the facility Administrator to review the above noted employee file findings. An interview was conducted with Employee J and she stated the purpose of and importance of a sworn statement is, "So they don't make false claims on their background checks and criminal offenses and make sure they don't have a criminal history or barrier crime". On 7/29/21 at approximately 11:00 AM, Surveyor E met with the Facility Administrator and Human Resources Coordinator/Employee J to review the above noted findings and review any additional documents they had to submit. The above noted items were still outstanding/incomplete. On 7/29/21, review of the facility policy titled, "Abuse Prevention and Management Policy" was	F 607	identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee quarterly. 5. Date of Compliance: 9/01/2021	

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F 607	Continued From page 19 conducted. This policy read, "Screening a) The organization will screen potential employees for a history of abuse, neglect or mistreating residents i) If employment references cannot be obtained, personal references may be obtained.....Virginia Specific Requirements: Screening. A) Each applicant will provide a sworn statement or affirmation disclosing any criminal convictions or any pending criminal chargers, whether within or outside the Commonwealth". The Administrator and Director of Nursing (DON) were made aware of the findings again on 7/29/21, during the end of day meeting. No further information was received.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse	F 656		9/1/21

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F 656	Continued From page 20 treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to develop a comprehensive care plan for one Resident (Resident #13) in a sample size of 22 Residents. For Resident #13, the facility staff failed to include: 1) focus, goals, and interventions addressing his pressure wounds 2) focus, goals, and interventions addressing his limited range of motion. The findings included:	F 656	1.) Resident #13 was assessed by nursing staff and medical record reviewed. The residents care plan has been updated to reflect a current individualized plan of care. 2.) The Director of Nursing/designee has performed an audit of all current residents□ care plans. Care plans have been updated to ensure individualized needs are addressed appropriately and that results are being tracked and addressed appropriately. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to	

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F 656	Continued From page 21 Resident #13, a 76-year old male, was admitted to the facility on 05/23/2019. Diagnoses for Resident #13 included but are not limited to diabetes mellitus, dementia, aphasia, reduced mobility, and generalized muscle weakness. Resident #13's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/10/2021 was coded as an annual assessment. The Brief Interview for Mental Status was not assessed. On 07/27/2021 at 8:53 A.M., Resident #13 was observed in his bed. Resident #13 was positioned on his back with the head of the bed elevated approximately 60 degrees. Resident #13 had soft boots on both feet and a bed extender in place. On 07/27/2021 at approximately 10:40 A.M., the active physician's orders for Resident #13 were reviewed. An order with a start date of 05/12/2021 documented, "Wash site on right heel with Dakin' solution and cover with calcium alginate AG and cover with foam dressing three times a week." An order with a start date of 05/12/2021 documented, "Wash area to right heel with Dakin's solution 0.25% prior to dressing change 3 x [three times] a week." An order with a start date of 05/12/2021 documented, "Apply foam dressing to bilateral heels." On 07/27/2021 at approximately 11:30 A.M., Resident #13's care plan was reviewed. There were only 2 focus areas listed. One focus dated 02/23/2021 documented, "Resident is unable to initiate in social interaction due to COVID-19, social distancing in small groups and hallway activities." The other focus dated 02/24/2021 with a revision date of 06/04/2021 documented, "[Resident #13] is at	F 656	update the care plans to reflect the needs identified. 3.) The Director of Nursing/designee has in-serviced nursing leadership and interdisciplinary team members regarding care plan updates. The in-service includes, but no limited to, the importance of care plan reviews and updates with any changes for each resident and care plans being reflective of individualized care needs. 4.) The Director of Nursing/designee will conduct an audit of 25% of resident care plans weekly for four weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. The Director of Nursing/designee will also audit the care plans of any new admissions daily for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	

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F 656	Continued From page 22	F 656		

nutritional risk due to diagnoses of cardiovascular disease, diabetes and dysphagia. Has the nutritional problem or potential nutritional problem due diagnosis of dysphagia and receives a pureed diet." There was not a focus, goal, or interventions addressing pressure wounds/pressure wounds prevention.

On 07/28/2021 at 10:37 A.M., an interview with Licensed Practical Nurse A (LPN A) was conducted. When asked about wound treatment for Resident #13, LPN A stated the night shift usually does Resident #13 dressings so she would have to look. LPN A accessed Resident #13's electronic health record and reviewed the physician orders. LPN A stated that there was an order to cover both heels with a foam dressing three days a week. LPN A stated Resident #13 had one wound on the right heel and the foam dressing on the left was preventative. LPN A also stated there was a wound treatment order for the right heel. This surveyor requested to observe a skin and wound assessment. LPN A and this surveyor then entered Resident #13's room for the skin and wound observation. Following the skin assessment, LPN A removed the soft boots to reveal a foam dressing on each heel. Each foam dressing was dated 07/28/2021. LPN A partially removed the left heel dressing to reveal a wound. A small amount of drainage and a calcium alginate dressing were observed on the inside of the foam dressing [calcium alginate for the left heel was not listed in the physician orders]. When asked to describe the wound bed, LPN A stated, "The wound bed is black." LPN A then partially removed the foam dressing on the right heel to reveal the wound. When asked to describe the wound, LPN A stated that it was a "necrotic ulcer with mild drainage."

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On 07/28/2021 at 3:10 P.M., the Director of Nursing (DON) was interviewed. When asked about the expectation for staff if there is a change in condition regarding skin assessments, the DON stated staff are expected to notify the DON, ADON, and nurse practitioner if there is a change in condition. The DON stated that the area would be assessed or reassessed, that staff would collaborate, develop interventions and have a plan of care.

On 07/27/2021 at 8:53 A.M., Resident #13 was observed in his bed. Resident #13 was positioned on his back with the head of the bed elevated approximately 60 degrees. Resident #13 had soft boots on both feet and a bed extender in place. Resident #13 did not have a palm guard on his left hand.

On 07/27/2021 at approximately 10:40 A.M., the active physician's orders for Resident #13 were reviewed. An order with a start date of 05/11/2021 documented, "Apply brace every morning and remove at bedtime."

On 07/27/2021 at approximately 11:30 A.M., Resident #13's care plan was reviewed. There were only 2 focus areas listed. One focus dated 02/23/2021 documented, "Resident is unable to initiate in social interaction due to COVID-19, social distancing in small groups and hallway activities." The other focus dated 02/24/2021 with a revision date of 06/04/2021 documented, "[Resident #13] is at nutritional risk due to diagnoses of cardiovascular disease, diabetes and dysphagia. Has the nutritional problem or potential nutritional problem due diagnosis of

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dysphagia and receives a pureed diet." There was not a focus, goal, or interventions addressing limited range of motion.

On 07/28/2021 at 8:25 A.M., Resident #13 was observed in his bed. Resident #13 was positioned on his back with the head of the bed elevated approximately 60 degrees. Resident #13 had soft boots on both feet and a bed extender in place. Resident #13 did not have a palm guard on his left hand.

On 07/28/2021 at approximately 10:40 A.M., this surveyor and LPN A entered Resident #13's room for a skin and wound observation. At approximately 10:45 A.M., Certified Nursing Assistant E (CNA E) entered Resident #13's room to assist LPN A reposition Resident #13 during the skin and wound observation. This surveyor observed a palm guard on the bedside table. When asked why Resident #13 did not have his palm guard on, CNA E stated he didn't know why. CNA E then placed the palm guard on Resident #13's left hand.

On 07/29/2021 at 8:43 A.M., an interview with Employee Q, the Director of Rehabilitative Services, was conducted. Employee Q verified that the order for a brace for Resident #13 was the left hand palm guard. Employee Q referred to his electronic health record and stated that Resident #13 had an evaluation on 02/04/2021 for a new palm guard. Employee Q referred to the therapy discharge summary dated 02/22/2021 and stated that Resident #13 met discharge goals and tolerated the left hand palm guard without difficulty. When asked about the importance of wearing the palm guard, Employee Q stated wearing the palm guard is important to protect

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F 656	Continued From page 25 skin integrity and to mitigate contractures. On 07/29/2021 at 9:30 A.M., the DON was interviewed. When asked about Resident #13's care plan, the DON stated that Resident #13's care plan needed to be "revised, updated, and improved." On 07/29/2021 mid-morning, the facility Administrator stated they are still in the process of updating Resident care plans because they didn't transfer over from the previous EHR [electronic health record] which changed 2/1/21. When asked if the facility staff providing direct Resident care had access to the old system's care plans she stated, "No, they only gave 4 of us access and several of them are no longer here." On 07/29/2021, the facility staff provided a copy of their policy entitled, "Care Plans, Comprehensive Person-Centered." Under the header entitled, "Policy Statement", it was documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." On 07/29/2021 at approximately 12:15 P.M., the administrator and DON were notified of findings. By the end of survey, the administrator stated there was no further documentation to submit.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F 677		9/1/21

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F 677	Continued From page 26 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to provide adequate care for 1 dependent (#28) in a survey sample of 22 Residents. The findings included: Resident number 28, an 86 year old woman admitted to the facility on 8/8/17, with diagnosis of but not limited to anemia, hypertension, hypothyroidism, Rheumatoid arthritis and major depressive disorder. Resident #28's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/7/21, coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 10. Section G coded this resident as (3) extensive assistance with one person physical assist for bed mobility, (4) total dependence for transfers requiring two persons or more physical assistance and the use of mechanical lift, she is coded as (3) extensive assistance one person physical assistance for dressing, she is independent with set up help only for meals, she is coded as (4) total dependent for toileting, and bathing. G0400 functional limitations in range of motion (A) upper extremity impairment on both sides (B) lower extremity coded as to impairment on both sides G0600 mobility devices (C) wheelchair. For walking she is coded as (8) activity did not occur. She is unable to stand or bear weight. She can self-propel with her wheel chair for mobility and is coded as independent for locomotion on and off the unit with the	F 677	1.) Residents #28 was assessed and interviewed by nursing staff and interviewed by social services. The resident and provider were notified of bathing patterns and schedule. The resident□s plan of care was reviewed and updated to reflect their resident-specific needs. 2.) Nursing staff performed assessments and interviews with residents and recorded results in medical record. Nursing has notified residents, responsible parties and provider of bathing patterns and schedule for residents. A resident council meeting was held in August 2021 to address call light concerns with residents and to ensure residents that corrective actions are being taken to reduce call light response times. 3.) The Director of Nursing/designee has in-serviced clinical nursing staff, including RNs, LPNs, CNA□s and NAs regarding call bell response time and shower schedules. The in-service includes, but is not limited to, the importance of showers and regular bathing and call bell response times. 4.) The Director of Nursing/designee will meet with staff five times a week for 6 weeks to review showers, bathing, and call bell response times. The Director of Nursing/designee will audit ADL documentation and progress notes five	

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F 677	Continued From page 27 wheelchair. The resident was alert oriented and very interactive during resident Council. Her questions and comments were on topic and made complete sense. On 7/27/21 at approximately 2:30 a Resident Council meeting was held and Resident #28 was in attendance. Resident # 28 was oriented to person, place, time, and situation. She actively participated in the meeting. A review of the Resident Council Minutes reflect that the slow call bell response times had been mentioned in March 2021, April 2021, May 2021, and June 2021. The Residents were asked about the facility response to the topic of call bell times, "Resident #28 stated that someone will come in and say I will be back they cut off the light and never come back." Resident #28 stated she has waited sitting on the bedpan for up to an hour waiting for staff to return. Resident #28 asked the question "Why do I have to have a cat and dog fight to get a shower?" When asked about her shower experience she stated that is was "horrible." She stated she knew she had the right to get 2 showers a week but she felt she had to fight to get them. She also stated the staff come to her room with the shower chair and undress her, wrap her in a sheet, then push her down the hall in the shower chair dressed only in a sheet. She stated "Sometimes there is a line and I have to wait in the hallway dressed like that until the other person in the shower is finished" When asked how that made her feel she "Why do they punish us like that?	F 677	times weekly for six weeks to ensure that showers and bathing are being completed per policy and call bell response times are appropriate. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate action will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	

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F 677	Continued From page 28 That's what it feels like punishment." She also made the comment "They should not treat us this way, it just ain't right." 07/28/21 10:09 AM, interview was conducted with the Administrator who was asked if there were issues with staffing at the facility, she said "At times yes." She was then asked if it impacted the care of the Residents, she said "It may put a delay on things like call bell responses." When asked if there were any resident complaints of care due to short staffing she answered, "No complaints but they have made the comments about having to wait longer for care." On 7/29/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 677		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff	F 686	1.) Residents #13, #19 and #5 were	9/1/21

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interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to prevent, identify, and appropriately treat pressure wounds for 3 Residents (Resident #13, Resident #19, Resident #5) in a sample size of 22 Residents.

The findings included:

1. For Resident #13, the facility staff failed to identify, assess, notify provider, and appropriately treat a pressure wound on the left heel resulting in an unstageable pressure wound on the left heel. This is harm.

Resident #13, a 76-year old male, was admitted to the facility on 05/23/2019. Diagnoses for Resident #13 included but are not limited to diabetes mellitus, dementia, and aphasia. Resident #13's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/10/2021 was coded as an annual assessment. The Brief Interview for Mental Status was not assessed. Resident #13's height was coded as 72 inches. Resident #13's weight was coded as 131 pounds. Risk of Pressure Ulcers was coded as "1" meaning "yes." Unhealed Pressure Ulcers was coded as "1" meaning "Yes." Number of Stage 2 pressure ulcers was coded as "1" meaning "one."

On 07/27/2021 at 8:53 A.M., Resident #13 was observed in his bed. Resident #13 was positioned on his back with the head of the bed elevated approximately 60 degrees. Resident #13 had soft boots on both feet and a bed extender in place.

On 07/27/2021 at approximately 10:40 A.M., the

assessed by nursing staff. The provider was notified of findings and of current wound care orders, and wound care orders were reviewed, and updated if needed, to ensure that they were appropriate treatment for each resident□s pressure ulcer(s). Wound care was administered to each resident as ordered by the provider. Plans of Care were revised to meet current needs of each resident.

2.) Nursing staff has performed and recorded results of head-to-toe skin assessments on all current residents. Results are recorded and tracked by Director of Nursing/designee. Nursing has notified the provider of any new pressure ulcers identified during these assessments and appropriate treatments were initiated per provider orders. Nursing staff has ensured that care plan interventions are appropriate and address resident specific skin care needs. Weekly head-to-toe skin assessments are being performed on all residents and results are being tracked and addressed appropriately by Director of Nursing/designee. A new wound care module was implemented in the EHR to assist with tracking, documentation, and staging of pressure ulcers.

3.) The Director of Nursing/designee has in-serviced all clinical nursing staff, including RNs, LPNs, CNAs and NAs regarding early identification and prevention of pressure ulcers. The in-service includes, but is not limited to,

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active physician's orders for Resident #13 were reviewed. An order with a start date of 05/12/2021 documented, "Wash site on right heel with Dakin' solution and cover with calcium alginate AG and cover with foam dressing three times a week." An order with a start date of 05/12/2021 documented, "Wash area to right heel with Dakin's solution 0.25% prior to dressing change 3 x [three times] a week." An order with a start date of 05/12/2021 documented, "Apply foam dressing to bilateral heels." There were no wound treatment orders for the left heel.

On 07/28/2021 at 8:25 A.M., Resident #13 was observed in his bed. Resident #13 was positioned on his back with the head of the bed elevated approximately 60 degrees. Resident #13 had soft boots on both feet and a bed extender in place.

On 07/28/2021 at 10:37 A.M., an interview with Licensed Practical Nurse A (LPN A) was conducted. When asked about wound treatment for Resident #13, LPN A stated the night shift usually does Resident #13 dressings so she would have to look. LPN A accessed Resident #13's electronic health record and reviewed the physician orders. LPN A stated that there was an order to cover both heels with a foam dressing three days a week. LPN A stated Resident #13 had one wound on the right heel and the foam dressing on the left was preventative. LPN A also stated there was a wound treatment order for the right heel. This surveyor requested to observe a skin and wound assessment. LPN A and this surveyor then entered Resident #13's room for the skin and wound observation. Following the skin assessment, LPN A removed the soft boots to reveal a foam dressing on each heel. Each foam dressing was dated 07/28/2021. LPN A

the importance of routine monitoring of residents skin, pressure ulcer prevention, and the appropriate actions to take if skin breakdown is identified.

4.) The Director of Nursing/ Designee will meet with staff five times weekly for 6 weeks to review care plan interventions to address specific resident skin care and pressure ulcer prevention and treatment needs. The Director of Nursing/ designee will review all active wound care orders and wound tracking and documentation weekly for six weeks to ensure appropriate treatments are ordered and the treatments are being completed as ordered. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate orders will be obtained. The Director of Nursing/designee will identify any trends and/or patterns, identify any additional education and training and provide the training on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis.

5.) Date of Compliance: 9/1/2021

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partially removed the left heel dressing to reveal a wound. A small amount of drainage and a calcium alginate dressing were observed on the inside of the foam dressing [calcium alginate for the left heel was not listed in the physician orders]. When asked to describe the wound bed, LPN A stated, "The wound bed is black." LPN A then partially removed the foam dressing on the right heel to reveal the wound. When asked to describe the wound, LPN A stated that it was a "necrotic ulcer with mild drainage."

On 07/28/2021 at 11:36 A.M., an interview with the nurse practitioner, Employee I, was conducted. When asked about [Resident #13]'s heel wounds, Employee I stated that Resident #13's heels were boggy but "when I checked them a few weeks ago, they opened and had purulent drainage." When asked about wound treatment, Employee I stated that [Resident #13] had an appointment with the wound clinic last week but the family cancelled the appointment. Employee I also stated that the appointment was re-scheduled for "tomorrow [07/29/2021]." When asked to describe the wound bed for both heels when she saw them a few weeks ago, Employee I indicated that the wound beds were "pink." When asked if she had seen the wounds since, Employee I stated, "No." This surveyor requested a wound observation with Employee I. Employee I, Employee G (the Assistant Director of Nursing (ADON)), and this surveyor entered Resident #13's room for a wound observation. Employee I partially removed the dressing on the right heel. While looking at the right heel wound, Employee I stated that "It's worse." Employee I stated that "[Resident #13] has eschar here and it's pink around the edges." Employee I then partially removed the dressing on the left heel. When

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asked to describe the wound, Employee I stated, "There's eschar here and pink around the edges." After exiting the room, Employee I stated that she was "not aware the wounds looked like this." When asked about the expectation for change in condition, Employee I stated she would expect to be notified if there were changes in wound appearance. When asked what the wound treatment would be had she known, Employee I stated she would consider ordering santyl [a chemical debriding agent].

On 07/28/2021, the provider progress notes for Resident #13 were reviewed. The most recent documentation from Employee I, the nurse practitioner, was a progress note dated 05/10/2021. Under the header, "Physical Exam" and sub-header "Skin" it was documented, "The bilateral foot wounds appear to have started as deep tissue injury to bilateral heels that have now opened. He has the anti-pressure boots on bilaterally."

On 07/28/2021, the weekly wound assessments from 03/24/2021 through 07/27/2021 were reviewed.
There were no assessments addressing a wound on the left heel.

On 07/28/2021, the nursing progress notes entitled, "Skin Only" from 02/04/2021 through 07/26/2021 were reviewed. There were no nursing progress notes addressing a wound on the left heel with the exception of the following:

A noted dated 05/10/2021 at 10:40 A.M. documented the following headers and entries:
"Skin Evaluation: Skin warm & dry
skin color: WNL [within normal limits],

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mucous membranes: moist,
turgor: normal.
Resident has current skin issues.
Skin Issue: Other open lesions of the foot.
Skin issue location: Bilateral heels
Wound odor: No.
Tunneling: No.
Undermining: No.
Tissue: Warm.
Skin note: Skin is warm and dry. Resident has no new areas."

A note dated 07/26/2021 at 7:00 A.M. documented the following headers and entries: "Skin Evaluation: Skin is ashen in color. Mucous membranes are moist. Skin warm/dry to touch. Skin is fragile. Decreased skin turgor. Resident has current skin issues.
Skin Issue: Pressure Ulcer /Injury.
Skin issue location: bilateral heels. Tx [treatment] in place.
Wound odor: Yes.
Tunneling: No.
Undermining: No.
Tissue: Painful.
Tissue: Mushy.
Tissue: Boggy.
Skin note: Treatment in place. Awaiting wound clinic appointment.
Resident / Responsible Party aware of diagnosis and plan of care: Yes."

On 07/28/2021 at 3:10 P.M., the Director of Nursing (DON) was notified of findings. When asked about the expectation for staff if there is a change in condition regarding skin assessments, the DON stated staff are expected to notify the DON, ADON, and nurse practitioner if there is a change in condition. The DON stated that the

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area would be assessed or reassessed, that staff would collaborate, develop interventions and have a plan of care. When asked about the expectations of staff for wound assessments, the DON stated the expectation is describe the wound and obtain measurements. When asked about the skin assessments for [Resident #13]'s heels, the DON stated she will assess, get measurements, and document results today.

On 07/28/2021 at approximately 3:30 P.M., the administrator was notified of concerns regarding lack of assessments or wound treatment for [Resident #13]'s left heel wound.

On 07/29/2021, a document entitled, "Weekly Wound Observation" was reviewed. It was completed by the DON and dated 07/28/2021 at 6:24 P.M. The following headers and entries were included but not limited to:
"Location: left heel
Date acquired: 7/28/2021
Type: pressure
Pressure Injury Stage: Stage 2: partial thickness skin loss with exposed dermis
Overall Impression: First Observation, no reference.
Visible Tissue: Moist
Drainage: Serous
Amount: Small
Odor present? No
Wound Measurements: length (cm[centimeters]): 5.2; width (cm): 4.4 Depth (cm): 0.1
Describe the extent of any tunneling and or undermining: Well defined, 3.4 [length] x 3.0 [width] soft, brown macule mid of site.
Describe wound edges and shape: well-defined.
Describe any changes to treatment plan in the last week: Discussed change in wound care to

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begin when medication is available: Cleanse site with Vashe, apply santyl as per manufacturer's policy cover with non stick dressing."

On 07/29/2021 at 9:30 A.M., an interview with the DON was conducted in the conference room with Surveyors A, B, C, and E also present. When asked about the expectation for wound assessments, the DON stated that the LPN's can describe a wound but they cannot stage wounds. When asked about the initial assessment for wounds, the DON stated that she would do the initial assessment and the staging. The DON also stated that she would like to have the nurse practitioner involved as well. When asked what stage Resident #13's left heel was, the DON stated she would need to change her documentation on the assessment [from 07/28/2021] because "the left heel wound is unstageable because I can't tell with the macule in the center."

On 07/29/2021 at 11:55 A.M., LPN A stated that Resident #13 just returned from the wound clinic. A copy of the treatment orders were requested and the facility staff provided a copy of a two-page document entitled, "Physician Order Details" which included instructions for wound cleansing, dressing changes, and off-loading.

On 07/29/2021 at 1:39 P.M., an interview with the Wound Physician, Employee M, was conducted. The Wound Physician verified she examined and treated the bilateral heel wounds for Resident #13 this day. When asked what stage the wounds were, the Wound Physician stated both heels wounds were very similar; and both heel wounds were unstageable because "he has black, dry, eschar on both heels." The Wound Physician also

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stated that the wound edges have started to lift. The Wound Physician also stated some of the eschar was debrided this day but because [Resident #13] has limited mobility, the plan is to remove the eschar slowly to allow for healing between visits.

On 07/29/2021, the facility staff provided a copy of their policy entitled, "Skin Assessment." Section 1 under the header entitled, "Policy Explanation and Compliance Guidelines", it was documented, "A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/readmission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury."

On 07/29/2021 at 2:25 P.M., the facility nurse consultant, Employee K, provided an amended copy of the nurse practitioner's note dated 05/10/2021. The amended progress note documented the following:

Under the header, "Addendum" it was documented, "In reference to the skin assessment, there is an error in documentation. The left heel is boggy and hyperpigmented, while the right heel is open with appropriate wound care orders in place. There are bilateral off-loading boots in place and his repositioning is every two hours per standard. He is positioned to alleviate pressure on his heels."

On 07/29/2021 by the end of survey, the administrator stated there was no further documentation or information to submit.

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2. For Resident # 19 the facility staff failed to prevent the development of pressure areas.

Resident #19, a 77 year old man admitted to the facility on 3/28/18 with diagnoses of but not limited to COPD, oxygen dependent, major depressive disorder, chronic A-Fib, peripheral vascular disease, chronic respiratory failure, hypertension, intervertebral disc degeneration and neuromuscular dysfunction of bladder.
Resident #19's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5/18/21, a quarterly review, coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13, indicating mild cognitive impairment. The MDS also coded the resident as requiring extensive assistance with all aspects of ADL care as well as bed mobility. The Resident cannot stand bear weight or walk.
The Resident is transferred by mechanical lift he is not coded as using a wheelchair.

On 7/27/21 during clinical record review it was discovered that Resident #19 had pressure areas to his buttocks. A review of the Residents care plan for pressure ulcers read as follows:

"FOCUS:
[Resident #19 name redacted] has a pressure ulcer to his left Ischium. Date Initiated 6/11/21 Revision on 6/11/21"

"GOAL:
[Resident #19 name redacted] will [sic] Pressure ulcer will show signs of healing and remain free from infection by through review date. . Date

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F 686	Continued From page 38 Initiated 6/11/21 Revision on 6/11/21 Target Date: 9/9/21" "INTERVENTIONS: Administer medications as ordered. Monitor/document for side effects and effectiveness Date. Initiated 6/11/21 Administer treatments as ordered and monitor effectiveness. Date Initiated 6/11/21 Assess/record/ monitor wound healing Measure length Width and depth where possible. Assess and document status of wound perimeter, wound healing and progress, Report improvements and declines to MD. Date Initiated 6/11/21 Follow facility policies/protocol for the prevention/treatment of skin breakdown Date Initiated 6/11/21 Inform the Resident/family/caregivers of any new area of skin breakdown Date Initiated 6/11/21 Instruct assist Resident to shift weight in Wheelchair. Date Initiated 6/11/21" A review of the facility policy and procedure entitled "Preventive Protocols" revealed the following excerpts: "All Residents" "Will be provided pressure reducing devices for beds and chairs. Additional devices may be used to support positioning and redistribution of weight." "Residents who require assistive devices to promote repositioning, will be provided such devices and staff assistance as needed." "Treatment Protocols" "Apply pressure redistribution mattress or overly	F 686		

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mattress to bed [Gel, water, intermittent air etc.]"
"Change position frequently [recommended at least 3-4 times per shift] when resident is in bed or chair."
"Provide incontinent care timely and apply barrier cream after cleansing each incontinent episode."

A review of physicians revealed the Resident had the following orders which were not reflected in the care plan:
"5/11/21 -Keep heels floated while in bed"
"5/11/21 - Barrier Cream to buttocks"
"5/11/21 - Skin Prep to right heel"
"5/11/21 - Weekly Skin assessment"

On 7/27/21 at approximately 8:45 AM an interview was conducted with CNA D who was asked how she knew the care needs of the Residents. She went to a Kiosk in the hall and said "All CNA's have access to the Kiosks, and it has the Kardex and the Care Plan in it. If I am not sure of how to transfer or if I am not sure if the Resident needs to use a lift to transfer, then I would look in the Kardex and if I'm still not sure I check the care plan."

On 7/28/21 at approximately 2:00 PM an interview was conducted with the ADON who was asked if interventions to prevent and treat pressure ulcers should be outlined in the care plan, she stated they should be. When asked if she would expect to see things like float heels, or use of air mattress in a care plan she stated that she would expect that to be in the care plan. When asked the purpose of the care plan she stated that it drives the care of the Resident. It tells the staff what to do and how to care for the Resident. When asked who uses the care plan

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she stated that the nursing staff including both nurses as well as CNA's all had access to it and should be using it.

On 7/29/21 at approximately 10:00 AM an interview was conducted with the DON who was asked about wound care processes. The DON was asked what the expectation is for nurses who discover a wound. She stated that if a wound was discovered the nurse would do the initial assessment and staging. When asked if there is a dedicated wound care nurse she stated that there was not. When asked who would do the initial assessment she stated the nurse assigned to him or her. She was then asked if it was acceptable for an LPN to do an initial wound assessment and she stated that it was not. She stated that she or another RN would do the Staging and initial assessment. When asked if she would expect to see the actual wound and treatments and prevention listed on the care plan she stated "I would expect to see the wounds addressed on the care plan and interventions should be listed on the care plan as well."

On 7/29/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

3. For Resident # 5 the facility staff failed to prevent the development of new pressure areas.

Resident #5 a 90 year old woman admitted to the

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facility on 7/20/20 with diagnoses of but not limited to osteoarthritis, foot drop (right), hypertension, chronic gout, muscle weakness, and chronic dvt (deep vein thrombosis). Her most recent MDS (Minimum Data Set) with an ARD (assessment reference date) of 4/22/21 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13 out of a possible 15 indicating mild cognitive impairment. She was also coded as requiring extensive assistance of 1 person physical assistance bed mobility, dressing, and hygiene. She was coded as being totally dependent of staff for transfers (using a mechanical lift), bathing, and locomotion on and off unit using a wheelchair. She cannot stand or bear weight.

On 7/27/21 at 8:30 AM an interview was conducted with Resident #5 and she was dressed in a gown and lying in bed on her back with the head of bed elevated to 45 degrees. When she was asked about any skin issues or pressure areas. Resident #5 said "I have a few sores on my bottom but they are taking care of them."

A review of the skin assessments were conducted excerpts are as follows:
"Date 7/06/21" Page 1
'SK. Skin"
"Does Resident have a current skin issue? [Box checked] Yes"
"Skin issue #1 - [box checked] G discoloration"
"SK 5B"
"Location - Buttocks"
"Length - [box left blank Width [box left blank] Tissue [box not checked.]"

Page 2
"Skin Note: - Resident has new area of redness

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F 686	Continued From page 42 noted on both sides of her buttocks. Frequent changes of undergarment and cream applied to buttocks at each change" "NT - Provider Notification - [All boxes for provider and Resident/ Responsible party notification were left blank.]" "Date 7/13/21" Page 1 "SK. Skin" "Does Resident have a current skin issue? [Box checked] Yes" "Skin issue #1 - [box checked] G discoloration" "SK 5B" "Location - Buttocks" "Length - [box left blank Width [box left blank] Tissue [box not checked.]" "Skin Note: No new skin areas noted at this time." "NT - Provider Notification - - [All boxes for provider and Resident/ Responsible party notification were left blank.]" "Date 7/19/21" Page 1 "SK. Skin" "Does Resident have a current skin issue? [Box checked] NO" "Skin Note: Skin is dry to BLE [bilateral lower extremities] treatment in place. No new skin issues." "NT - Provider Notification - - [All boxes for provider and Resident/ Responsible party notification were left blank.]" "Date 7/26/21" "SK. Skin" "Does Resident have a current skin issue? [Box checked] Yes" "Skin issue #1 - [box checked] G discoloration" "SK 5B - Location - Buttocks"	F 686		

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"SK 5C -Pressure ulcer / injury stage B - Stage 2 - Partial thickness skin loss."
Length - [box left blank Width [box left blank] Tissue [box not checked.]"

A review of the progress notes revealed:
7/26/21 - 11:50 PM Skin issue: Deep tissue pressure injury (DTPI) Skin issue location buttocks
Pressure Ulcer / Injury Stage II -Partial thickness skin loss. Wound odor NO. Tunneling NO Undermining NO Tissue Mushy. No new skin issues at this time."

A review of the clinical record revealed that Resident #5 has an orders that read:
"Apply Z guard ointment between buttocks fold and apply dry dressing. Date started 5/11/21"
"Heel boots in place to feet every shift Date started 5/11/21"
"Resident to use mosaic roho cushion when up in wheelchair Date started 5/11/21"
"Skin prep bilateral heels every day and night shift Date started 5/11/21"
"Baza Protect Cream (skin protectant) apply to buttocks topically with incontinence care and PRN Date started _5/16/21 at 3:45 PM"
"Calf pad insert to wheelchair Date started 5/16/21"

On 7/28/21 at approximately 11:30 AM an observation was made of Resident #5's documented pressure area to sacrum. LPN B and Surveyor C went to Resident #5's room and found Resident was laying on her back in the bed with head of bed elevated 45 degrees. The Resident was asked if Surveyor C (a Registered Nurse)

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could view the wound to her sacrum and she agreed. The area to the sacrum was not open however it was quarter sized, pink, fragile looking, and appeared to have been newly healed. The Resident was dressed in a gown and did not have heel boots or other pressure reducing devices. She stated "It doesn't bother me so bad until I have to wait to be changed then it does. I was wet today for 2 hours before I got changed."

A review of the care plan was conducted and excerpts are as follows:
"FOCUS"
"[Resident #5 name redacted] has the potential for pressure ulcer development r/t h/o pressure ulcers, bowel and bladder incontinence, advanced age with fragile skin, preference to remain in bed laying on back." Date initiated - 7[/1/21 Revision on 7/1/21"

"GOAL"
"[Resident #5 name redacted] will have intact skin free of redness blisters or discoloration by / through review date. Date initiated 7/1/21 Revision on: 7/1/21 Target DATE: 6/13/21" [sic]

"INTERVENTIONS"
"Follow facility policies / protocols for the prevention /treatment of skin breakdown Date Initiated 7/1/21 Revision on 7/1/21"

"Inform [Resident #5 name redacted] /family/caregivers of any new area of skin breakdown Date Initiated 7/1/21 Revision on 7/1/21."

"Monitor nutritional status. Serve diet as ordered, monitor intake and record. Date Initiated 7/1/21

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Revision on 7/1/21."

"Monitor / document/ report PRN any changes in skin status; appearance, color, wound healing, s/sx of infection, wound size (length X width X depth), stage Date Initiated 7/1/21 Revision on 7/1/21."
"Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated 7/1/21 Revision on 7/1/21."
The above mentioned skin assessments did not have signatures or nurses names printed on the documents.

On 7/29/21 at approximately 10:00 AM an interview was conducted with the DON who was asked about wound care processes. The DON was asked what the expectation is for nurses who discover a wound. She stated that if a wound was discovered the nurse would do the initial assessment and staging. When asked if there is a dedicated wound care nurse she stated that there was not. When asked who would do the initial assessment she stated the nurse assigned to him or her. She was then asked if it was acceptable for an LPN to do an initial wound assessment and she stated that it was not. She stated that she or another RN would do the Staging and initial assessment. When asked if she would expect to see the actual wound and treatments and prevention listed on the care plan she stated "I would expect to see the wounds addressed on the care plan and interventions should be listed on the care plan as well."

On 7/29/21 the Administrator was made aware of the concerns and no further information was

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F 686	Continued From page 46 provided.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide appropriate treatment and services for the prevention of further decrease in range of motion for one Resident (Resident #13) in a sample size of 22 Residents. For Resident #13, the facility staff failed to provide a left palm guard on 07/27/2021 and 07/28/2021 as ordered by the physician. The findings included:	F 688	1.) Resident #13 was assessed by nursing and therapy for decrease in previous function to left hand with no decrease in function noted. Resident #13 has had his left palm guard in place per MD order with removal for skin checks, ADL care and range of motion. Plan of care has been updated to identify and manage resident personalized care needs. 2.) The DON/Designee has performed an audit to identify all residents with current orders for a palm guard. Residents	9/1/21

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F 688	Continued From page 47 Resident #13, a 76-year old male, was admitted to the facility on 05/23/2019. Diagnoses for Resident #13 included but are not limited to diabetes mellitus, dementia, aphasia, reduced mobility, and generalized muscle weakness. Resident #13's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 05/10/2021 was coded as an annual assessment. The Brief Interview for Mental Status was not assessed. On 07/27/2021 at 8:53 A.M., Resident #13 was observed in his bed. Resident #13 was positioned on his back with the head of the bed elevated approximately 60 degrees. Resident #13 had soft boots on both feet and a bed extender in place. Resident #13 did not have a palm guard on his left hand. On 07/27/2021 at approximately 10:40 A.M., the active physician's orders for Resident #13 were reviewed. An order with a start date of 05/11/2021 documented, "Apply brace every morning and remove at bedtime." On 07/28/2021 at 8:25 A.M., Resident #13 was observed in his bed. Resident #13 was positioned on his back with the head of the bed elevated approximately 60 degrees. Resident #13 had soft boots on both feet and a bed extender in place. Resident #13 did not have a palm guard on his left hand. On 07/28/2021 at approximately 10:40 A.M., this surveyor and LPN A entered Resident #13's room for a skin and wound observation. At approximately 10:45 A.M., Certified Nursing Assistant E (CNA E) entered Resident #13's room	F 688	identified by the audit were assessed by nursing and therapy for decrease in previous function to affected hand(s). The DON/designee ensured that palm guards were in place per MD order with removal for skin checks, ADL care and range of motion. Plans of care have been updated to identify and manage resident-specific care needs. 3.) The Director of Nursing/designee has in-serviced clinical nursing staff, including RNs, LPNs, CNAs and NAs regarding hand splints and range of motion, along with skin checks. The in-service includes, but is not limited to, the importance of hand splints, range of motion and skin checks and reporting any concerns or refusals to supervisor. 4.) The Director of Nursing/designee will perform an observation audit of all residents with palm guards 5 times weekly for 6 weeks to ensure proper use and placement. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	

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F 688	Continued From page 48	F 688		

to assist LPN A reposition Resident #13 during the skin and wound observation. This surveyor observed a palm guard on the bedside table. When asked why Resident #13 did not have his palm guard on, CNA E stated he didn't know why. CNA E then placed the palm guard on Resident #13's left hand.

On 07/29/2021 at 8:43 A.M., an interview with Employee Q, the Director of Rehabilitative Services, was conducted. Employee Q verified that the order for a brace for Resident #13 was the left hand palm guard. Employee Q referred to his electronic health record and stated that Resident #13 had an evaluation on 02/04/2021 for a new palm guard. Employee Q referred to the therapy discharge summary dated 02/22/2021 and stated that Resident #13 met discharge goals and tolerated the left hand palm guard without difficulty. When asked about the importance of wearing the palm guard, Employee Q stated wearing the palm guard is important to protect skin integrity and to mitigate contractures.

On 07/29/2021, the facility staff provided a copy of their policy entitled, "Restorative Nursing Program." In Section 6 (b), it was documented, "Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assessed to have a need for restorative nursing services. These services may include ...splint or brace assistance."

On 07/29/2021 at approximately 12:15 P.M., the administrator and DON were notified of findings. By the end of survey, the administrator stated there was no further documentation to submit.

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F 695	Continued From page 49	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility failed to provide oxygen therapy consistent with infection control measures and the plan of care for 2 Residents (Resident # 17 and # 19) in a survey sample of 22 Residents in the survey sample. Findings included: 1. For Resident # 17, the facility staff failed to change the oxygen tubing and humidifier bottle weekly as ordered. Resident # 17 was a 72-year-old who was admitted to the facility on 03/31/2021 with diagnoses of but not limited to: Acute and Chronic Respiratory Failure, Hypoxia, Hypercapnia, Supraventricular tachycardia, Chronic Diastolic Heart Failure, Chronic Obstructive Pulmonary Disease, Bilateral Osteoarthritis of Knee and Hypertension. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment	F 695	1.) Resident #17 has had oxygen tubing and humidifier bottle changed weekly per order. The residents provider was notified of nursing process of weekly tubing and humidification bottle changes. The resident s plan of care was reviewed and updated to include resident-specific needs. 2.) An observation audit of oxygen tubing and humidification bottles was performed on all residents receiving oxygen. Any tubing or bottles found with dates older than one week were immediately replaced. 3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding oxygen tubing changes and humidification bottle changes weekly. The in-service includes, but is not limited to, the importance of weekly changes of oxygen tubing and humidification bottles and labeling with the date of change and reporting any concerns to supervisor.	9/1/21

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F 695	Continued From page 50 Reference Date (ARD) of /11/2017. The MDS coded Resident # 17 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of 1 staff person with Activities of Daily Living. Resident # 17 was coded as frequently incontinent of bowel and bladder. During initial tour on 7/27/2021 at 8:45 AM, Resident # 17 was observed with oxygen via nasal cannula at 2 liters per minute. The Oxygen tubing was dated 7/5/2021 and the oxygen humidifier bottle was dated 7/5/2021. On 7/27/2021 at 9:55 AM, Registered Nurse A was observed passing medications. Registered Nurse A was interviewed about the facility's policy on changing oxygen equipment. Registered Nurse A stated the oxygen tubing and set up should be changed weekly. Registered Nurse A went with Surveyor B to look at the date on oxygen tubing and humidifier bottle for Resident # 17. Registered Nurse A stated "it should have been changed weekly. This has not been changed since July 5th." When asked about the importance of changing the oxygen tubing and humidifier bottle weekly, Registered Nurse A stated "for infection control. It needs to be changed weekly to prevent the spread of infections." Review of the clinical record was conducted on 7/27/2021; On 7/27/2021 at 2:20 PM, observed the date on the oxygen tubing and humidifier bottle. Both were still dated 7/5/2021. On 7/28/2021 at 9:15 AM, observed the date on	F 695	4.) The Director of Nursing/designee will perform an observation audit of oxygen tubing and humidification bottles weekly for six weeks to ensure that the bottles and tubing are changed as per the provider orders. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	

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F 695	Continued From page 51	F 695		

the oxygen tubing and humidifier bottle. Both were still dated 7/5/2021.

On 7/28/2021 at 11:20 AM, an interview was conducted with Resident # 17 who stated the oxygen tubing had "not been changed recently."

Review of Physicians Orders revealed an order "to change and label oxygen tubing humidifier bottle and masks weekly,every night shift every Sunday for Infection Control Ordered 7/19/2021

On 7/28/2021 at 2:40 PM, an interview was conducted with the Assistant Director of Nursing who stated the Oxygen tubing and humidifier bottle should be changed and dated weekly on the night shift on Sunday nights. The Assistant Director of Nursing went with Surveyor to Resident # 17's room to look at the oxygen tubing and humidifier. The date on the tubing and humidifier bottle still was 7/5/2021. The Assistant Director of Nursing stated the tubing should have been changed. The Assistant Director of Nursing gathered the oxygen equipment to change the tubing.

On 7/29/2021 at 8:45 AM, observed the oxygen tubing and humidifier bottle were dated 7/28/2021. Resident # 17 stated "they changed it yesterday afternoon."

During the debriefing with Administrative staff on 8/15/2018 at 1:30 PM, the Assistant Administrator, Director of Nursing, and Corporate Nursing Consultants (Employee k) were informed of the findings.

On 7/21/2021 at 12: 15 PM during the end of day debriefing, the facility Administrative staff stated

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F 695	Continued From page 52	F 695		

the oxygen tubing and equipment for all residents receiving oxygen had been checked on 7/28/21 to make sure they were changed timely. They stated the oxygen tubing and humidifier bottle should be changed weekly.

No further information was provided.

2. For Resident # 19 the facility staff failed to change weekly and date the oxygen tubing, nebulizer set up and humidifier bottle as ordered.

Resident #19, a 77 year old man admitted to the facility on 3/28/18 with diagnoses of but not limited to COPD, oxygen dependent, major depressive disorder, chronic A-Fib, peripheral vascular disease, chronic respiratory failure, hypertension, intervertebral disc degeneration and neuromuscular dysfunction of bladder.
Resident #19's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5/18/21, a quarterly review, coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13, indicating mild cognitive impairment. The MDS also coded the resident as requiring extensive assistance with all aspects of ADL care as well as bed mobility. The Resident cannot stand bear weight or walk.
The Resident is transferred by mechanical lift he is not coded as using a wheelchair.

On 7/27/21 at approximately 8:43 AM, Resident #19 was observed asleep lying in bed on his back, he had the nasal cannula prongs correctly inserted in his nose and the tubing was over his ears and secured under his chin. The Oxygen concentrator was at his bedside and operating correctly, however the oxygen tubing was not connected to the Oxygen concentrator, nor was

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there a humidifier bottle attached to the concentrator. CNA D was in the hallway and was asked to enter the room of Resident #19.

On 7/27/21 8:45 AM an interview was conducted with CNA D, who was asked if she saw anything wrong or out of the ordinary about the Resident's oxygen. She said "Oh No it's not connected the tubing is under his back." She proceeded to wake the Resident and assist him to turn over and retrieved the oxygen tubing and connected it to the oxygen concentrator. Upon exiting the room she was asked what the dangers of not having the oxygen hooked up to the concentrator could possibly be and she stated that the Resident would not be able to breathe. She obtained the pulse oximeter and checked the Resident's Oxygen Saturation which was 97% at that time. The Resident was asked how he felt and he stated that he felt ok. He was asked if he felt short of breath he answered that he did not.

When the Oxygen tubing was inspected by the surveyor and CNA D it was found to have a date of 7/19/21 on it.
The hand held nebulizer machine was on the over bed table with tubing and nebulizer cup connected to the machine not in a bag.

On 7/28/21 at approximately 10:00 AM another observation was made of Resident #19 lying in bed on his back asleep and the oxygen tubing was still dated 7/19/21 there was still no humidifier bottle and the nebulizer tubing and cup remained connected to the machine, not dated and un-bagged.

On 7/28/21 a review of the clinical record revealed the following orders:

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"5/13/21 at 7:00 PM - Change and label oxygen tubing and humidifier bottles every night shift every Thursday."
"5/13/21 at 7:00 PM - Nebulizer administration set/tubing change every night shift every Thursday."

A review of the facility policies for Oxygen and Nebulizer Machines was conducted excerpts are as follows:

"Policy: Oxygen concentrators are used to administer oxygen to residents to improve oxygenation and provide comfort to residents experiencing respiratory difficulty."

"Guidelines:"
"Humidification is required, if ordered by physician, if flow rate is 4 liters or greater or if oxygen is used with a trach."
"Oxygen cannula/mask/humidifier bottle should be changed at least weekly and PRN."

"Policy: Nebulizer via Hand-Held Nebulizer Machine"
Purpose: To deliver aerosol medications. To promote a better ventilation / profusion ratio by decreasing bronchodilation."

"After Each Treatment:"
"Disconnect the nebulizer cup from the tubing."
"Rinse the disposable nebulizer and mouthpiece thoroughly with hot tap water and clean the cup and all pieces in mild soap and water (do not was or rinse tubing)."
"Store the dried nebulizer cup and tubing in a plastic bag"
"Replace the nebulizer cup, mouthpiece, or mask and tubing weekly. Label the tubing with the date

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F 695	Continued From page 55 when changed weekly." On 7/28/21 an interview with the ADON was conducted and she was asked what her expectation was with regard to nebulizer and oxygen tubing, she stated that they should be dated, and changed weekly just as outlined in the policy. On 7/29/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 695		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to	F 732		9/1/21

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F 732	Continued From page 56 residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post the nurse staffing timely and daily, resulting in the potential for inaccurate information to be presented to residents and visitors. Findings included: During an observation on 07/27/21 at 9:30 AM, there was no daily nursing staff report posted in the main lobby nor on any of the bulletin boards in the hallway or near the nurses station. On 07/29/21 at 9:55 AM, an interview was conducted with the Director of Nursing who stated the facility did have the nurse staffing hours posted. The Director of Nursing was asked to show Surveyor B where the staffing hours were posted. The Director of Nursing went to the nurses station, opened a drawer and retrieved a black notebook that held a daily schedule. When Surveyor B asked if the information was posted where the general public could view it, the Director of Nursing stated "no." The Director of	F 732	1.) Facility staff have corrected this alleged deficient practice. The daily nursing staff report is being posted at the nurses station daily. 2.) Director of Nursing/designee reviews daily nursing staff report and ensures it is posted visible to the general public daily. Audits of posting have been performed since 8/1/21 and results are being tracked and addressed appropriately by Director of Nursing/designee. 3.) The Director of Nursing/designee has in-serviced clinical nurses including RNs and LPNs on night shift and nursing management, to include but not limited to, how to complete daily nursing staff report posting and where to post this information so that it is visible to general public. 4.) The Director of Nursing/designee will review daily postings for placement and accuracy five times weekly for six weeks.	

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F 732	Continued From page 57 Nursing stated the facility used to have the posting of the nurse staffing hours on a bulletin board near the Solarium Room near the Nurses station. She stated the nursing staffing hours were not posted in a visible place. On 7/29/2021 during the end of day debriefing, the facility Administrator was informed of the findings. The Administrator stated she was aware that the nursing staffing information was supposed to be posted in an area readily accessible to residents and visitors. The Administrator stated the staffing information used to be posted near the nurses station. The Administrator stated she did not realize the staffing information was not posted. No further information was provided.	F 732	Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate action will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		9/1/21

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F 755	Continued From page 58 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed for 1 resident (Resident # 540) in the survey sample of 22 residents, to ensure medications were available for administration. For Resident # 54, the facility staff failed to provide medications as ordered by the Physician. The findings included: For Resident # 54, the facility staff failed to provide medications as ordered by the Physician. Resident #54 was admitted to the facility on 4/19/19. Diagnoses for Resident # 54 included but were not limited to: CVA (cerebrovascular accident), Hypertension,, Diabetes, peripheral vascular disease, major depressive disorder and fracture of left humerus. Resident # 54's Minimum Data Set (an assessment protocol) with an Assessment	F 755	1.) Resident #54 has been assessed by nursing staff and provider with no negative outcomes noted. The resident, resident representative, and provider were notified of missing doses. Plan of care was reviewed and updated for individualized care needs. 2.) The Director of Nursing/designee has performed an audit of all medications administered by nursing staff since 8/1/2021. Any resident who has missed an administration of a medication has been assessed by nursing staff and the provider and resident representative have been notified. Plans of care have been reviewed and updated for individualized care needs. 3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding process for when a medication is not available. The in-service	

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F 755	Continued From page 59 Reference Date of 7/8/2021 coded Resident # 54 with a BIMS (brief interview of mental status) score of 15 out of 15 indicating no cognitive impairment. Activities of Daily Living care. Resident # 54 was coded as requiring extensive assistance of 2 person physical assistance for bed mobility and transfers. Resident # 54 required extensive assistance of one staff person for dressing and toileting. Resident # 54 was coded as requiring total dependence of one staff person for bathing. Resident # 54 used an electric wheel chair for mobility. Review of the clinical record was conducted on 7/27/2021. The following nursing notes were documented in the clinical record: 7/9/2021-Duloxetine 60 milligrams one cap by mouth ordered from Pharmacy. 7/10/2021-Duloxetine 60 milligrams one cap by mouth ordered from Pharmacy. 7/11/2021-Duloxetine 60 milligrams one cap by mouth ordered from Pharmacy. 7/11/2021- Metoprolol 25 milligrams one tablet by mouth twice a day- ordered from Pharmacy. According to the July 2021 MAR (Medication Administration Record), the medications were not administered on on the above medications . Review of STAT Box (Inventory of Replenishment Report) contents revealed the following: Duloxetine 30 milligrams DR (Delayed Release) capsule-Quantity: 5 in inventory Metoprolol 25 milligrams tablet Quantity: 5 in inventory.	F 755	includes, but is not limited to, notification to provider for new orders, accessing the STAT box, using a back-up pharmacy if medications are unavailable from the primary pharmacy, and reporting any concerns to the nursing supervisor. 4.) The Director of Nursing/designee will audit the MAR five times weekly for 6 weeks to review medication availability, accurate documentation, and provider notification. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	

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F 755	Continued From page 60 There was no documentation of the facility staff using medication from the Stat box or calling the physician to notify of the unavailable medications. Review of the facility documentation on Back up Pharmacies revealed there were four Pharmacies listed that were in close proximity to the facility for back up medications. There was no documentation of the facility staff contacting the four Back up Pharmacies listed on the facility documentation. There were valid Physicians Orders for the medications listed as unavailable. On 7/28/2021 at 2:45 PM, an interview was conducted with the Corporate Nurse Consultant who stated medications should be available for administration as ordered by the Physician. On 7/29/2021 during the end of day debriefing, the Administrator, Corporate Nurse and Director of Nursing were notified of the issue at the end of day meeting on 7/29/2021. The Corporate Nurse again stated medications should be available for administration as ordered by the Physician. No further information was provided.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, and	F 760	1.) Resident #6 has been assessed by	9/1/21

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F 760	Continued From page 61 facility documentation the facility staff failed to ensure 1 Resident (Resident #6) in a survey sample of 22 Residents, was free of significant medication errors. For Resident #6, the facility staff failed to provide the Resident with 10 doses Sevelamer Carbonate between 6/10/21 and 7/22/21. The findings included: Resident #6, a 72 year old man admitted to the facility on 3/4/19 with diagnoses of but not limited to end stage renal disease, dialysis dependent, hypertension, progressive neuropathy, idiopathic gout, difficulty walking, and anemia in kidney disease. Resident #6's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/25/21 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 14 out of 15 indicating no cognitive impairment. The Resident was also coded as requiring limited assistance 1-2 persons with transfers, dressing and total assistance for bathing. He is coded as requiring set up and or supervision for eating. The Resident uses a walker for aid in mobility. According to MEDLINEPLUS.GOV "Sevelamer is used to control high blood levels of phosphorus in people with chronic kidney disease who are on dialysis. Sevelamer is in the class of medications called phosphate binders. It binds phosphorus that you get in your diet and prevents it from being absorbed in the blood stream." On 7/28/21 during clinical record review it was found that Resident #6 had an order for Sevelamer Carbonate 800 mg to be given 4 times	F 760	nursing staff and provider with no negative outcomes noted. The resident, responsible party and provider were notified of missing doses. Plan of care was reviewed and updated for individualized care needs. 2.) The Director of Nursing/designee has performed an audit of all medications administered by nursing staff since 8/1/2021. Any resident who has missed an administration of a medication has been assessed by nursing staff and the provider and resident representative have been notified. Plans of care have been reviewed and updated for individualized care needs. 3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding process for when a medication is not available. The in-service includes, but is not limited to, notification to provider for new orders, accessing the STAT box, using a back-up pharmacy if medications are unavailable from the primary pharmacy, and reporting any concerns to the nursing supervisor. 4.) The Director of Nursing/designee will audit the MAR five times weekly for 6 weeks to review medication availability, accurate documentation, and provider notification. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education	

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F 760	Continued From page 62 a day. The progress notes document the medication not been given: 7/22/2021-10:39 PM Orders -Administration Note: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four Times a day related to END STAGE RENAL DISEASE not in from pharmacy. 7/22/2021 6:52 PM Orders - Note Text: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four times a day related to END STAGE RENAL DISEASE Awaiting from pharmacy 7/22/2021 -1:23 PM -Orders Administration Note SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four times a day related to END STAGE RENAL DISEASE Awaiting from pharmacy 7/21/2021 - 7:30 PM -Orders Administration Note Text: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four Times a day related to END STAGE RENAL DISEASE Awaiting from pharmacy 7/21/2021 11:22 AM Orders Administration Note Text: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four Times a day related to END STAGE RENAL DISEASE Awaiting from pharmacy 6/13/2021 8:10 PM Orders -Administration Note Text: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four times a day related to END STAGE RENAL DISEASE awaiting Rx from pharmacy	F 760	and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 9/1/2021	

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F 760	Continued From page 63	F 760		

6/13/2021 6:01 PM - Orders -Administration Note Text: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four times a day related to END STAGE RENAL DISEASE awaiting Rx from pharmacy

6/13/2021 11:48 AM-Orders -Administration Note Text: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four times a day related to END STAGE RENAL DISEASE awaiting on pharmacy.

6/13/2021 5:37 AM Orders -Administration Note Text: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four times a day related to END STAGE RENAL DISEASE awaiting from pharmacy

6/10/2021 7:54 PM Orders -Administration Note Text: SEVELAMER CARBONATE 800MG TAB Give 1 tablet by mouth four times a day related to END STAGE RENAL Disease awaiting from pharmacy

On 7/28/21 at approximately 2:00 PM an interview was conducted with LPN B who stated that if there is not a medication available to give the Resident "We first check the STAT box then call the pharmacy, and then if they can't get it here we call the MD and see if he wants to give something else, then we document and let the Resident or RP know."

On 7/29/21 at approximately 12:40 PM the ADON was asked what her expectation was for the nurses when a medication was not available for a Resident. The DON stated that it was her expectation that the nurse would first check the

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F 760	Continued From page 64 STAT box, then call the pharmacy, notify the physician and the Resident or RP and document all of it. On 7/29/21 a review of the STAT box contents revealed the medication was not available, however the progress notes do not document the pharmacy or MD or RP being notified. On 7/29/21 the Administrator provided a list of "Back up Pharmacies" the list included 4 possible pharmacies they could use. One pharmacy that was 1.92 miles away from the facility and one that was 13.35 miles away, both of those pharmacies had hours of operation that were 7 days a week. The other two that were listed were under 30 miles away and both of those had 24 hour service. None of them were utilized to get the medication for this Resident. On 7/29/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 760		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		9/1/21

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F 812	Continued From page 65 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to store and prepare foods in accordance with professional standards in one out of one facility kitchens. Specifically, the facility staff failed to: 1) measure food temperatures for cold and steam table foods for lunch and dinner on 07/23/2021; and all 3 meals on 07/24/2021, 07/25/2021, and 07/26/2021 (11 out of 12 meals). 2) ensure the #4 walk-in refrigerator, #8 freezer, and #8 low-boy freezer were maintained at acceptable temperature ranges on 07/20/2021-07/26/2021. 3) ensure dishwasher was reaching acceptable temperatures during the wash and rinse cycles in order to properly sanitize dishes on 07/10/2021, 07/13/2021, 07/21/2021, 07/22/2021, and 07/26/2021. The findings included: On 07/27/2021 at 7:55 A.M., Employee C, a cook, was interviewed in the kitchen. Employee C verified she has worked in the kitchen for 25 years. When asked about the temp logs,	F 812	1. During the survey process all food, refrigerator, freezer, and dishwasher temperatures were found to be safe and in an acceptable range. Beginning July 27, 2021, the Certified Dietary Manger began in-servicing the dietary staff on the importance of documenting temperatures on the appropriate logs. 2. The Certified Dietary Manger, designee, will check the dietary temperature logs (to include food, refrigerator, freezer, and dishwasher) each shift to ensure the logs are accurate and being properly completed. 3. The Certified Dietary Manager, designee, will in-service all dietary staff on How to properly store and prepare food in accordance with professional standards to include the importance of checking food, refrigerator, freezer, and dishwasher temperatures and recording them on the appropriate logs. 4. The Certified Dietary Manger, designee will perform daily audits of the temperature logs for six (6) weeks to ensure substantial compliance is	

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F 812	Continued From page 66 Employee C presented a log book and stated all the logs are in the one book. Employee C and this surveyor observed the logs for the steam table, refrigerator, freezers, and dishwasher. The following observations were made on each of the logs: 1) The log entitled, "Freezer Checklist" under the sub-header "Month" documented, "July 21." Under the sub-header "Location" it was documented, "#8 freezer." The document contained a table with columns labeled "Date", "Temperature", and "Initials." The following dates did not have temperatures recorded: 07/20/2021-07/26/2021. 2)The log entitled, "Refrigeration Checklist" under the sub-header "Month" documented, "July 21." Under the sub-header "Location" it was documented, "#4 walk-in." The document contained a table with columns labeled "Date", "Temperature", and "Initials." The following dates did not have temperatures recorded: 07/20/2021-07/26/2021. 3) The log entitled, "Freezer Checklist" under the sub-header "Month" documented, "July 21." Under the sub-header "Location" it was documented, "#8 low-boy." The document contained a table with columns labeled "Date", "Temperature", and "Initials." The following dates did not have temperatures recorded: 07/20/2021-07/26/2021. 4) The log dated "July 2021" entitled, "Dishwashing Machine Form" contained a table with columns labeled, "Breakfast Temperature", "Lunch Temperature", and "Dinner Temperature."	F 812	achieved. The Certified Dietary Manager will report any trends, patterns or concerns during the next QAPI meeting. 5. Date of compliance: 9/01/2021	

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F 812	Continued From page 67	F 812		

Each meal had temperatures recorded for wash and rinse cycles. The following days were blank: 07/10/2021, 07/13/2021, 07/21/2021, 07/22/2021, and 07/26/2021.

5) The log entitled, "Pot Sink Sanitation Record" was blank.

When asked where the pages were for the steam table food temperatures for 07/24/2021, 07/25/2021, 07/26/2021, and 07/27/2021, and the missing temperatures on the refrigerator, freezers, and dishwasher logs, Employee C acknowledged they were missing. When asked about the food temperatures missing for lunch and dinner on 07/23/2021, Employee C stated "I wasn't here; I'm just getting back."

On 07/27/2021 at 8:32 A.M., an interview with the Dietary Manager, Employee E was conducted. When asked why the log entitled, "Pot Sink Sanitation Record" was blank, Employee E stated that they don't use the pot sink but they use the dishwasher every day. When asked about the expectation the dishwasher temperature log, Employee E stated that staff should be checking the dishwasher temps every day to make sure it reaches the right temperatures so that "dishes are being cleaned properly." When asked about the expectation for the other temperature logs, Employee E stated she will have a mandatory meeting with staff and go over the importance of checking the temperatures and writing them down.

On 07/27/2021 at 9:02 A.M., the administrator was notified of findings.

On 07/29/2021, the facility provided a copy of

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F 812	Continued From page 68 their policy entitled, "Dishwashing Machine Use." An excerpt in Section 8 under the header, "Policy Interpretation and Implementation" documented, "The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log." On 07/29/2021, the facility provided a copy of their policy entitled, "Food Preparation and Service." In Section 1 under the header, "Food Preparation, Cooking and Holding Time/Temperatures", it was documented, "The 'danger zone' for food temperatures is between 41 [degrees Fahrenheit] and 135 [degrees Fahrenheit].. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness." In Section 2 under the header "Food Service/Distribution", it was documented, "The temperatures of foods held in steam tables are monitored throughout the meal by food and nutrition services staff." On 07/29/2021, the facility provided a copy of their policy entitled, "Refrigerators and Freezers." In Section 2 under the header "Policy Interpretation and Implementation", it was documented, "Monthly tracking sheets for all refrigerators and freezers will be maintained to record temperatures." On 07/29/2021 by the end of survey, the administrator stated they had no further documentation or information to submit.	F 812		
F 840 SS=D	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources.	F 840		9/1/21

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F 840	Continued From page 69 §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure the Residents had access to services outside the facility for 1 Resident (#19) in a survey sample of 22 Residents. For Resident #19 the facility staff failed to ensure he had transportation to the wound clinic and subsequently had to reschedule 7 appointments. The findings included: Resident #19, a 77 year old man admitted to the facility on 3/28/18 with diagnoses of but not limited to COPD, oxygen dependent, major depressive disorder, chronic A-Fib, peripheral vascular disease, chronic respiratory failure, hypertension, intervertebral disc degeneration	F 840	1. Resident #19 has been transported to his scheduled wound care appointments and has not missed a scheduled appointment due to transportation since 8/1/2021. Three Rivers Health and Rehab Center determined that no additional residents had a negative outcome resulting from this alleged deficient practice. 2. The Unit Secretary/ designee has reviewed all current resident medical records and developed a list of those residents requiring routine transportation services. A transportation log has been developed to monitor residents who require transportation services. All residents requiring transportation will be	

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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 840	Continued From page 70	F 840		

and neuromuscular dysfunction of bladder. Resident #19's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5/18/21, a quarterly review, coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 13, indicating mild cognitive impairment. The MDS also coded the resident as requiring extensive assistance with all aspects of ADL care as well as bed mobility. The Resident is transferred by mechanical lift he is not coded as using a wheelchair and he uses stretcher transportation for doctors' appointments.

On 7/27/21 at approximately 1:52 PM an interview was conducted with the unit secretary who schedules the appointments and transportation to appointments for the Resident. The unit secretary stated that she has had a lot of trouble obtaining stretcher transportation for Resident #19. She stated that it is hard to get both stretcher, and oxygen transport which Resident #15 needs. She said "Unfortunately with Medicaid patients it is often hard to get stretcher transport and when you do find stretcher transport they can't do the oxygen. So we tell them we will provide the oxygen canisters, and it is still a problem." She further stated that when they cannot find transportation they reschedule the appointment notify the Resident and/or the Responsible Party and the MD, and document in the chart.

On 7/27/21 during clinical record review it was discovered that Resident #19 developed a pressure area to his buttocks and was referred to the wound clinic. It was also documented that the Resident had appointments that the facility had to reschedule due to lack of transportation. The dates he could not attend are as follows:

added to the transportation log.

3. The Unit Secretary/ designee will monitor all residents added to the transportation log to ensure timely transportation is achieved. Residents whose transportation has not arrived or been cancelled by the transportation company will be set up with an alternative company, unless the transportation company can guarantee the next transport will be timely. Transportation cancellations will be reported to the Administrator.

4. The Administrator will review the transportation logs monthly. If identified trends are found, the Administrator will contact the transportation company directly to address service concerns and contact the local Ombudsman for assistance. All trends and patterns will be reported to the Quality Assurance and Performance Improvement Committee quarterly.

5. Date of compliance: 9/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495303	A. BUILDING _____ B. WING _____	C 07/29/2021

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3/26/21 at 10:30 AM (rescheduled for 4/9/21)
4/9/21 at 10:30 AM (rescheduled for 4/16/21)
4/16/21 at 9:00 AM (rescheduled for 4/22/21)
4/22/21 at 10:15 AM (rescheduled for 5/6/21)
5/6/21 at 10:15 AM (rescheduled for 5/28/21)
5/28/21 at 2:00 PM (rescheduled for 6/3/21)

On 7/28/21 a request was made to see the consult or visits from the wound clinic the facility could only produce 1 note dated 6/3/21. The wound clinic physician's note read:

"Wound #1 status is open, original cause of wound was pressure injury. The wound is currently classified as unstageable/ unclassified wound with etiology of pressure ulcer and is located on the right coccyx. The wound measures 2.8 cm length x 2 cm width x 0.1 cm depth 4.398 cm^2 area and o.44 cm^2 volume. There is a medium amount of serosanguinous drainage noted. There is a small (1-33%) red, pink granulation within the wound bed. There is a large (67-100%) of necrotic tissue in the wound bed including adherent slough."

"Wound #2 is open, original cause of wound was pressure injury. The wound is currently classified as unstageable/ unclassified wound with etiology of pressure ulcer and is located on the left ischium. The wound measures 1.7 cm length x 1.5 cm width x 0.1 depth. 2.003 cm^2 and 0.2 cm^3 volume. There is a small amount of serosanguinous drainage noted. There is a small (1-33%) red, pink granulation within the wound bed. There is a large (67-100%) of necrotic tissue in the wound bed including eschar and adherent slough."

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F 840	Continued From page 72 On 7/29/21 at approximately 2:00 PM an interview was conducted with the doctor from the wound care center who stated "Ideally we like to see them weekly or biweekly but during the Pandemic it has been difficult to do." She read the other physicians notes in the chart and stated that "Originally when he was seen it was a stage 4 or unstageable currently it's at a stage II." On 7/28/21 at approximately 11:00 AM an interview was conducted with the Administrator, about the transportation concerns. She stated that there was a problem getting transportation for stretcher with oxygen and under Medicaid. She stated they do have contracts with transportation however sometimes they do not find out until the day of that there is no one scheduled to pick up the Resident. When asked what is the process when this happens, she stated well certainly if its emergent we will get them there but if it is not an emergency "like a follow up dental or vision appointment we will reschedule it." When asked who is responsible for getting dependent residents to these appointments and she stated "Ultimately it is the facility responsibility to see they get to the appointments." On 7/29/21 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.	F 840		