STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495401	A. BUILDING _____ B. WING _____	C 08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TYLER'S RETREAT AT IRON BRIDGE	12001 IRON BRIDGE RD CHESTER, VA 23831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 8/3/21 through 8/5/21. 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 8/3/21 through 8/5/21. Two complaints were investigated during the survey (VA00052538 - substantiated without deficiency and VA00047112 - unsubstantiated). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 90 bed facility was 68 at the time of the survey. The survey sample consisted of 33 current resident reviews and four closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to ensure the accommodation of needs for one of 37 residents in the survey sample, Resident #29. The facility staff failed to place Resident #29's call	F 558	Corrective Action(s). Resident #29's call bell was placed in resident's reach and remains in reach while in room. Identification of Deficient Practice(s) & Corrective Action(s):	9/10/21

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

Electronically Signed | 08/25/2021

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F 558	Continued From page 1 bell within reach on 8/3/21 and 8/4/21. The findings include: Resident #29 was admitted to the facility on 6/21/21 with diagnoses including dementia (1) and bipolar disorder (2). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/22/21, Resident #29 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). She was coded as having had a fall in the month prior to admission, and as having had no falls since admission to the facility. Observations conducted on the following dates and time: 8/3/21 at 12:47 p.m. and 4:00 p.m.; 8/4/21 at 9:53 a.m., revealed Resident #29 was observed lying in bed. During each observation, Resident #29's call bell was lying on the floor behind the head of her bed. Further observation revealed there were no fall mats on the floor beside the resident's bed. A review of Resident #29's comprehensive care plan, dated 6/22/21, updated on 7/22/21, revealed, in part: "Minimize risks for falls/minimize injuries related to falls: "Fall mat to right side of bed...Implement preventative fall interventions/devices...Maintain call light within reach. Educate resident to use call light." On 8/4/21 at 12:53 p.m., LPN (licensed practical nurse) # 2 was interviewed. When asked where call bells should be placed in resident rooms, she stated the call bells should always be within a resident's reach. When asked who is responsible	F 558	A 100% audit of current resident's call bells was completed to ensure all were within reach of resident. Any negative findings were corrected at time of discovery. Systemic Change(s): All staff to include new hires and agency staff will be inserviced by the DON and/or ADON on proper call bell positioning and to ensure call bells are placed with in resident's reach. All new staff will be educated on maintaining call bell within residents reach during orientation. Monitoring: DON, ADON, and or Unit Manager will perform call bell audits 3x weekly x 12 weeks to monitor for compliance. Any negative findings will be corrected at time of discovery and reported to DON. Audit findings will be reported to QAPI committee for further review and recommendations monthly x 3 months.	

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F 558	Continued From page 2	F 558		

for making sure the call bells are in reach, LPN #2 stated, "It is everybody's responsibility. Everyone who enters the room."

On 8/4/21 at 3:44 p.m., RN (registered nurse) #3 was interviewed. She stated call bells should always be placed within a resident's reach. When asked if Resident #29 is capable of using her call bell, RN #3 stated, "Yes. She uses it from time to time."

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

On 8/5/21 at 8:43 a.m., CNA #5 was interviewed. When asked where a resident's call bell should be located, she stated it should be located within a resident's reach. When asked if Resident #29 is capable of using her call bell, she stated yes. She stated it is "everyone's responsibility" to make sure a resident's call bell is within reach. When asked why it is important for a resident's call bell to be within reach, CNA #5 stated, "Safety."

A review of the facility policy, "Resident Communication System and Call Light Policy," revealed, in part: "When the resident is in bed or confined to a chair, be sure the call light is within easy reach."

No further information was provided prior to exit.

REFERENCES
(1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases.

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F 558	Continued From page 3 It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (2) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 558		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility abuse policy to immediately report an allegation of abuse to the administrator/ abuse coordinator for one of 37 residents in the survey sample, Resident #31.	F 607	Corrective Action(s): In-service education was provided to all staff by Facility Administrator on the timing requirement to report all allegations of abuse immediately to Facility Administrator or Director of Nursing. Identification of Deficient Practice(s) &	9/10/21

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F 607	Continued From page 4 Resident #31 reported an allegation of abuse to facility staff on 1/16/21. The facility staff failed to immediately report this allegation to the facility administrator, ASM #1. ASM #1 stated he did not report Resident #31's allegation of abuse to the SA (state agency) and other officials until 1/19/21, because he was not made aware of the allegation until that date. The findings include: The facility abuse policy documented, "Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. 6) Initial Reports a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency..." Resident #31 was admitted to the facility on 1/3/20. Resident #31's diagnoses included but were not limited to stroke, chronic kidney disease and anxiety disorder. Resident #31's quarterly minimum data set assessment with an assessment reference date of 6/23/21, coded the resident's cognition as severely impaired. A nurse's note dated 1/16/21 documented, "resident refused medication stated this evening while other staff was around that she was beat up by this person that she named HR sec heard not close i to her name but also said that she was hiding from her husband all shift she was saying	F 607	Corrective Action(s): Current residents residing in the facility may have been potentially affected. A 100% audit of facility concern forms for the previous 30 days will be completed. Any negative findings of reportable occurrences will result in an internal investigation with appropriate notification of outcomes to state agencies, attending physician and responsible parties. Systemic Change(s): The facility Policy and Procedure for reporting resident abuse & neglect has been reviewed and no changes are warranted at this time. Facility staff, to include new hires and agency staff will be in-serviced by the administrator on the abuse prevention, investigation, and reporting policy. These in-services reviewed prevention, identifying, timely reporting and investigating of incidents and allegations of abuse, neglect or mistreatment of residents, resident to resident altercations and misappropriation of property that are reported. Monitoring: The Administrator will be responsible for maintaining compliance. Facility concern forms will be reviewed 5 times weekly x 12 weeks by the Administrator/designee to ensure any potential reportable events are investigated and reported as required. Confidential files of reported incidents and follow-up documentation will be maintained in the Administrator's office. Documentation will be reviewed monthly x 3 months by QAPI committee for further	

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F 607	Continued From page 5	F 607		

strange things like saying calling her name on the tv."

A FRI (facility reported incident) submitted to the SA on 1/19/21 documented, "Report Date: 1/19/21. Incident Date: 1/16/21. Residents Involved: (Resident #31). Injuries: No. Allegation of abuse/mistreatment. Incident was reported to Administrator regarding statement from resident (Resident #31) to her nurse. The resident stated that she had been beaten up and was hiding from her husband. A full body assessment was completed and the resident showed no signs of injury..."

The final report was completed on 1/25/21 and no abuse was found.

The nurse who documented the 1/16/21 nurse's note was no longer employed at the facility.

On 8/4/21 at 3:24 p.m., an interview was conducted with RN (registered nurse) #2 regarding a resident's allegation of abuse. RN #2 stated she is going to make sure the resident is safe, conduct a full body assessment, check the resident's skin, obtain vital signs then report an allegation of abuse to the director of nursing or administrator immediately after her assessment. RN #2 stated she would report an allegation of abuse within 20 to 30 minutes and no later than one hour.

On 8/4/21 at 5:01 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated an allegation of abuse must be reported to the SA within two hours. ASM #1 and ASM #2 (the director of nursing) were made aware of the

review or recommendations.

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F 607	Continued From page 6 above concern. On 8/5/21 at approximately 9:00 a.m., ASM #1 stated he did not report Resident #31's allegation of abuse until 1/19/21 because he was not made aware of the allegation until that date.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		9/10/21

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F 609	Continued From page 7 by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report an allegation of abuse was reported immediately but no later than two hours for one of 37 residents in the survey sample, Resident #31. Resident #31 reported an allegation of abuse on 1/16/21. The facility staff failed to report this allegation to the SA (state agency) until 1/19/21. The findings include: Resident #31 was admitted to the facility on 1/3/20. Resident #31's diagnoses included but were not limited to stroke, chronic kidney disease and anxiety disorder. Resident #31's quarterly minimum data set assessment with an assessment reference date of 6/23/21, coded the resident's cognition as severely impaired. A nurse's note dated 1/16/21 documented, "resident refused medication stated this evening while other staff was around that she was beat up by this person that she named HR sec heard not close i to her name but also said that she was hiding from her husband all shift she was saying strange things like saying calling her name on the tv." A FRI (facility reported incident) submitted to the SA on 1/19/21 documented, "Report Date: 1/19/21. Incident Date: 1/16/21. Residents Involved: (Resident #31). Injuries: No. Allegation of abuse/mistreatment. Incident was reported to Administrator regarding statement from resident (Resident #31) to her nurse. The resident stated that she had been beaten up and was hiding from	F 609	Corrective Action(s) In-service education provided to all staff by Facility Administrator on timeliness of reporting allegations of abuse. Identification of Deficient Practice(s) & Corrective Action(s): Current residents residing in the facility may have been potentially affected. A 100% audit of facility concern forms for the previous 30 days will be completed. Any negative findings of reportable occurrences will result in an internal investigation with appropriate notification of outcomes to state agencies, attending physician and responsible parties. Systemic Change(s): The facility Policy and Procedure for reporting resident abuse & neglect has been reviewed and no changes are warranted at this time. Facility staff, to include new hires and agency staff will be in-serviced by the administrator on abuse prevention, investigation and reporting policy. These in-services will focus on prevention, identifying, timely reporting and investigating of incidents and allegations of abuse, neglect or mistreatment of residents, resident to resident altercations and misappropriation of property. The Administrator is responsible for completing internal investigations for all reported incidents including injuries of unknown origin, abuse, neglect, unusual occurrences, misappropriation of resident property and resident to resident altercations.	

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F 609	Continued From page 8	F 609		

her husband. A full body assessment was completed and the resident showed no signs of injury..."

The final report was completed on 1/25/21 and no abuse was found.

The nurse who documented the 1/16/21 nurse's note was no longer employed at the facility.

On 8/4/21 at 3:24 p.m., an interview was conducted with RN (registered nurse) #2 regarding a resident's allegation of abuse. RN #2 stated she is going to make sure the resident is safe, conduct a full body assessment, check the resident's skin, obtain vital signs then report an allegation of abuse to the director of nursing or administrator immediately after her assessment. RN #2 stated she would report an allegation of abuse within 20 to 30 minutes and no later than one hour.

On 8/4/21 at 5:01 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator). ASM #1 stated an allegation of abuse must be reported to the SA within two hours. ASM #1 and ASM #2 (the director of nursing) were made aware of the above concern.

On 8/5/21 at approximately 9:00 a.m., ASM #1 stated he did not report Resident #31's allegation of abuse until 1/19/21 because he was not made aware of the allegation until that date.

The facility abuse policy documented, "Facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately

Monitoring:
The Administrator will be responsible for maintaining compliance. Facility concern forms will be reviewed 5 times weekly x 12 weeks by the Administrator/designee to ensure any potential reportable events are investigated and reported as required. Confidential files of reported incidents and follow-up documentation will be maintained in the Administrator's office. Documentation will be reviewed monthly x 3 months by QAPI committee for further review or recommendations.

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F 609	Continued From page 9 begin an investigation and notify the applicable local and state agencies in accordance with the procedures in this policy. 6) Initial Reports a. Timing. All allegations of Abuse, Neglect, Involuntary Seclusion, Injuries of Unknown Source, and Misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency..." No further information was presented prior to exit.	F 609		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the	F 622		9/10/21

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resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or

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F 622	Continued From page 11 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide all required documents to the receiving facility upon transfer for two of 37 residents in the survey sample, Residents #64 and #25. 1. The facility staff failed to evidence Resident #64's comprehensive care plan goals and other documents required to care for the resident were sent to the hospital when Resident #64 was transferred and discharged there on 7/23/21. 2. The facility staff failed to provide evidence Resident #25's comprehensive care plan goals were provided to receiving hospital staff when the resident was transferred to the hospital on	F 622	Corrective Action(s): Resident #64 and resident #25 have been discharged from the facility. Identification of Deficient Practice(s) & Corrective Action(s): A 100% audit of residents discharged or transferred to hospital in the past 30 days for required discharge documentation. Any negative findings will be corrected at time of discovery. Systemic Change(s): The DON and/or ADON will inservice licensed nursing staff, to include agency staff and new hires on the discharge/transfer procedure and the	

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F 622	Continued From page 12 6/26/21. The findings include: 1. Resident #64 was admitted to the facility on 7/21/21 with diagnoses including atrial fibrillation (1) and generalized weakness. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/22/21, Resident #64 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). A review of Resident #64's clinical record revealed the following progress note, dated 7/23/21: "Called the on-call dr (doctor) due to [Resident #64] stating his chest was hurting...she stated to send out to the ED (emergency department)...Resident left with EMS (emergency medical services) at 3:15 a.m...Spoke with the ED Nurse and she stated that he was being admitted...Patient is being admitted for a possible blood clot." Further review of Resident #64's clinical record failed to reveal any evidence that the resident's comprehensive care plan goals or physicians' orders had been sent to the receiving hospital on 7/23/21. On 8/4/21 at 3:24 p.m., RN (registered nurse) #2 was interviewed. When asked what information she provides to the hospital staff when a resident is sent to the hospital, she stated she sends the resident's face sheet, a transfer sheet, a change of condition report, a list of physicians' orders, MAR (medication administration record), and care plan goals. She stated she sends this	F 622	required documentation that is to be submitted to the receiving hospital or facility for the discharged resident. Monitoring: The DON and Social Services Director are responsible for compliance. The DON, ADON and/or Social services director will audit all residents discharged or transferred from the facility weekly to monitor for required documentation was submitted to the receiving facility for 12 weeks. Any negative finding will be corrected at time of discovery. Results of the audits will be will be reported to QAPI committee monthly X 3 months for review and recommendations.	

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information in an envelope. When asked if any of this is documented in the clinical record, RN #2 stated, "It should be."

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

On 8/5/21, ASM #2 was interviewed. When asked whether or not Resident #64's clinical record contained evidence that the required documentation had been sent to the hospital on 7/23/21, she stated she had not been able to locate it. When asked if this information should be included in the clinical record, ASM #2 stated it should.

On 8/5/21 at 8:35 a.m., LPN (licensed practical nurse) #5 was interviewed. When asked what documents should be sent to the hospital when a resident is transferred there, she stated the hospital should receive all physicians' orders, the MAR, care plan goals, and the transfer form. LPN #5 stated all of this should be documented in a progress note.

A review of the facility policy, "Discharge/Transfer Letter Policy," revealed no information related to documentation that should be sent to the hospital when a resident is discharged.

No further information was provided prior to exit.

REFERENCES
(1) "Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart

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rhythms. Atrial fibrillation causes your heart to beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation

2. Resident #25 was admitted to the facility on 6/14/21. Resident #25's diagnoses included but were not limited to muscle weakness, chronic kidney disease and pneumonia.

Resident #25's admission minimum data set assessment with an assessment reference date of 6/20/21, coded the resident's cognition as severely impaired.

Review of Resident #25's clinical record revealed the resident was transferred to the hospital on 6/26/21 because he removed his Foley catheter [a tube inserted into the bladder that drains urine] and staff had difficulty inserting a new catheter. Further review of Resident #25's clinical record including nurses' notes and a transfer form dated 6/26/21 failed to evidence that the facility staff provided the resident's comprehensive care plan goals to hospital staff.

On 8/4/21 at 3:24 p.m., an interview was

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F 622	Continued From page 15 conducted with RN (registered nurse) #2. RN #2 stated nurses are supposed to send a face sheet, transfer sheet, change of condition eInteract form, a copy of the physician order sheet, medication administration record and a copy of the physician's order for transfer when a resident is transferred to the hospital. RN #2 stated nurses should document that all this information was sent in a nurse's note. On 8/4/21 at 5:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		9/10/21

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(c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

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F 623	Continued From page 17 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to notify the	F 623	Corrective Action: Resident #69, #64 and #25 have been discharged from the facility.	

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F 623	Continued From page 18 resident and or RR (resident representative), and ombudsman in writing of the resident's discharge to the hospital for three of 37 residents in the survey sample, Residents #69, #64, and #25. The findings include: 1. The facility staff failed to notify the resident and or the RR in writing when Resident #69 was transferred and discharged to the hospital on 7/16/21. Resident #69 was admitted to the facility on 7/14/21 with diagnoses including endocarditis (1), COPD (chronic obstructive pulmonary disease) (2), and dementia (3). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/26/21, Resident #69 was coded as being moderately cognitively impaired for making daily decisions. A review of Resident #69's clinical record revealed the following progress note dated 7/16/21: "Contacted [name of local hospital] to f/u (follow up)...resident was admitted for aspiration PNA (pneumonia)." Further review of Resident #69's record failed to reveal any evidence that the resident and or the RR (resident representative) was notified in writing of the transfer. On 8/4/21 at 3:24 p.m., RN (registered nurse) #2 was interviewed. When asked how she notifies a resident or the RR of a discharge from the facility to the hospital, RN #2 stated, "You are supposed to call them." When asked if she ever provides written notification, RN #2 stated, "I have never heard of that."	F 623	Identification of Deficient of Deficient Practices & Corrective action(s): A 100% audit of residents discharged or transferred from the facility in the past 30 days will be completed to review for written notification of discharge to the resident and/or resident representative and the Ombudsman. Any/all negative finding will be corrected at time of discovery. Systemic Changes: The DON and/or ADON will inservice licensed nursing staff, to include agency staff and new hires on the Discharge/Transfer policy and procedure. The in-service training will cover the required documents to be submitted with a resident when they are discharged or transferred from the facility and the requirement that written notification being given to the resident and/or Resident representative and the Ombudsman indicating the reason for discharge from the facility. Monitoring: The DON is responsible for compliance. The DON, ADON and/or Unit Manager will audit all residents being transferred or discharged from the facility weekly x 12 weeks to monitor that written documentation was submitted to resident and/or resident representative and ombudsman indicating reason for discharge. Any negative findings will be corrected at time of discovery. Results of the audits will be forwarded to the DON or	

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On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

On 8/5/21, ASM #2 was interviewed. When asked if she had been able to locate evidence that Resident #69 or the RR had been notified in writing of the discharge to the hospital on 7/16/21, she stated she had not.

A review of the facility policy, "Discharge/Transfer Letter Policy," revealed, in part: "The Facility will complete discharge letters appropriately and according to all federal, state, and local regulations."

REFERENCES
(1) "Infectious endocarditis is the inflammation of the endocardium, the inner lining of the heart, as well as the valves that separate each of the four chambers within the heart. It is primarily a disease caused by bacteria and has a wide array of manifestations and sequelae." This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK557641/.

(2) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

(3) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment,

designee for review. The audit findings will be reported to the QAPI committee for review and recommendations monthly x 3 months.

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and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.

2. The facility staff failed to notify the resident/RR in writing when Resident #64 was discharged to the hospital on 7/23/21.

Resident #64 was admitted to the facility on 7/21/21 with diagnoses including atrial fibrillation (1) and generalized weakness. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/22/21, Resident #64 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status).

A review of Resident #64's clinical record revealed the following progress note, dated 7/23/21: "Called the on-call dr (doctor) due to [Resident #64] stating his chest was hurting...she stated to send out to the ED (emergency department)...Resident left with EMS (emergency medical services) at 3:15 a.m...Spoke with the ED Nurse and she stated that he was being admitted...Patient is being admitted for a possible blood clot."

Further review of Resident #64's clinical record failed to reveal evidence that Resident #64 or the RR had been notified in writing of the discharge to the hospital on 7/23/21.

On 8/4/21 at 3:24 p.m., RN (registered nurse) #2 was interviewed. When asked how she notifies a resident or the RR of a discharge from the facility to the hospital, she stated: "You are supposed to

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call them." When asked if she ever provides written notification, she stated: "I have never heard of that."

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

On 8/5/21, ASM #2 was interviewed. When asked if she had been able to locate evidence that Resident #64 and or the RR had been notified in writing of the discharge to the hospital on 7/16/21, she stated she had not.

No further information was provided prior to exit.

REFERENCES
(1) "Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes your heart to beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation.

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3. Resident #25 was transferred to the hospital on 6/26/21. The facility staff failed to provide written notification of the transfer to the ombudsman and Resident #25's representative.

Resident #25 was admitted to the facility on 6/14/21. Resident #25's diagnoses included but were not limited to muscle weakness, chronic kidney disease and pneumonia. Resident #25's admission minimum data set assessment with an assessment reference date of 6/20/21, coded the resident's cognition as severely impaired.

Review of Resident #25's clinical record revealed the resident was transferred to the hospital on 6/26/21 because he removed his Foley catheter (a tube inserted into the bladder that drains urine) and staff had difficulty inserting a new catheter.

Further review of Resident #25's clinical record (including nurses' notes and a transfer form dated 6/26/21) revealed the resident's representative was notified of the transfer but failed to reveal that written notification of the transfer was provided to Resident #25's representative. Also, the clinical record failed to contain evidence that written notification of the transfer was provided to the ombudsman.

On 8/4/21 at 3:24 p.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated nurses do not notify the ombudsman when a resident is transferred to the hospital. RN #2 further stated that nurses call the representative but she had never heard of providing written notification of transfer to representatives.

On 8/4/21 at 5:01 p.m., ASM (administrative staff

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F 623	Continued From page 23 member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 8/4/21 at 5:24 p.m., an interview was conducted with OSM (other staff member) #1 (the social services director and person responsible for notifying the ombudsman of hospital transfers). OSM #1 stated she did not send notice of Resident #25's hospital transfer on 6/26/21 to the ombudsman because she did not know the resident had been transferred to the hospital. No further information was presented prior to exit.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 37 residents in the survey sample, Resident #21. The facility staff failed to complete assessments for sections B0700, B0800 and section C of Resident #21's quarterly MDS with an ARD (assessment reference date) of 6/12/21. The findings include: Resident #21 was admitted to the facility on 5/27/20. Resident #21's diagnoses included but	F 641	Corrective Action(s): Resident #21 has had their most recent MDS modified to accurately code section B & C. Resident #21's comprehensive care plan has been reviewed to ensure Cognition and Communication interventions are in place and accurate. Identification of Deficient Practice(s) and Corrective Action(s): A 100% audit of all residents current MDS assessments will be completed by the MDS coordinators and/or designee to ensure that sections B & C of the MDS are coded correctly. All negative findings	9/10/21

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F 641	Continued From page 24 were not limited to high blood pressure, chronic respiratory failure and pain. Review of Resident #21's quarterly MDS with an ARD of 6/12/21 revealed sections B0700 and B0800 (assessments of whether the resident can make self-understood and whether the resident can understand others) were not completed. Also, section C (a cognition assessment) was not completed with the resident or with staff. On 8/5/21 at 7:53 a.m., an interview was conducted with RN (registered nurse) #4 (the MDS coordinator and person responsible for completing section B). RN #4 stated she was trained to code section B based on section C and Resident #21's cognition was not assessed for section C on the 6/12/21 MDS so she did not assess the resident for B0700 and B0800. On 8/5/21 at 7:56 a.m., an interview was conducted with OSM (other staff member) #1, the social services director and person responsible for completing section C. OSM #1 stated the cognitive assessment for section C of Resident #21's 6/12/21 MDS was missed and not done. On 8/5/21 at 9:36 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The Centers for Medicare and Medicaid Services Resident Assessment Instrument manual documented the following, "B0700: Makes Self Understood Health-related Quality of Life ·Problems making self-understood can be very frustrating for the resident and can contribute to social isolation and mood and behavior disorders.	F 641	will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS and the residents comprehensive care plan will be revised as needed. Systemic Change(s): The Resident Interdisciplinary Care Team has been inserviced by the Regional Clinical Nurse and/or DON on the proper assessment and coding of sections B & C of the MDS. Monitoring: The DON and MDS coordinator are responsible for monitoring compliance. MDS assessment audits will be completed weekly for 12 weeks coinciding with the MDS calendar to monitor for compliance. All negative finds from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the QAPI committee monthly x 3 months for review, analysis and recommendations for change in facility policy, procedure and or practice.	

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F 641	Continued From page 25	F 641		

· Unaddressed communication problems can be inappropriately mistaken for confusion or cognitive impairment.
Steps for Assessment
1. Assess using the resident's preferred language or method of communication.
2. Interact with the resident. Be sure he or she can hear you or have access to his or her preferred method for communication. If the resident seems unable to communicate, offer alternatives such as writing, pointing, sign language, or using cue cards.
3. Observe his or her interactions with others in different settings and circumstances.
4. Consult with the primary nurse assistants (over all shifts) and the resident's family and speech-language pathologist...
B0800: Ability to Understand Others
Health-related Quality of Life
·Inability to understand direct person-to-person communication
- Can severely limit association with others.
- Can inhibit the individual's ability to follow instructions that can affect health and safety.
Planning
Steps for Assessment
1. Assess in the resident's preferred language or preferred method of communication.
2. If the resident uses a hearing aid, hearing device or other communications enhancement device, the resident should use that device during the evaluation of the resident's understanding of person-to-person communication.
3. Interact with the resident and observe his or her understanding of other's communication.
4. Consult with direct care staff over all shifts, if possible, the resident's family, and speech-language pathologist (if involved in care).
5. Review the medical record for indications of

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F 641	Continued From page 26 how well the resident understands others... SECTION C: COGNITIVE PATTERNS Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions..." No further information was presented prior to exit.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		9/10/21

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F 655	Continued From page 27 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop a baseline care plan for two of 37 residents in the survey sample, (Residents #59 and #69). For Resident #59, the facility staff failed to develop a base line care plan for the use of side rails. For Resident #69, the facility staff failed to develop a care plan for the use of side rails. The findings include: 1. Resident #59 was admitted to the facility on 7/13/21 with diagnoses including history of a heart attack and heart failure. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/19/21, Resident #59 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was	F 655	Corrective Action(s): Resident #59's comprehensive care plan has been updated to include the use of quarter rails for assistance with repositioning while in bed. Resident #69 is no longer at the facility. Identification of Deficient Practice(s) & Corrective Action(s): A 100% review of all new admissions in the last 30 days will be conducted by the MDS Coordinators and or designee to identify residents who did not have an accurate baseline care plan completed to address the use of quarter rails. All residents identified will have their comprehensive care plan reviewed and updated to reflect the use of quarter rails for turning and repositioning. Systemic Change(s):	

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F 655	Continued From page 28 coded as requiring the assistance of two staff members for bed mobility. On the following dates and times: 8/3/21 at 12:22 p.m. and 3:48 p.m.; 8/4/21 at 9:48 a.m. and 4:05 p.m. observations revealed Resident #59 was observed lying in bed with her eyes closed. At each of these observations, bilateral side rails were up at the head of the resident's bed. A review of Resident #59's clinical record revealed a Side Rail Evaluation form dated 7/13/21. The form documented the resident's assessment for the use of side rails, the explanation of risks and benefits, and the date of informed consent for the use of the side rails. A review of Resident #59's baseline care plan dated 7/14/21 revealed no evidence of any information related to her use of side rails. On 8/4/21 at 12:53 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if side rails should be included on a resident's care plan, LPN #2 stated, "Yes, if it is necessary for resident safety, it should be care planned." On 8/4/21 at 3:15 p.m., RN (registered nurse) #1, the MDS nurse, was interviewed. When asked if side rails should be included on a resident's baseline care plan, RN #1 stated the facility used to put side rails on every resident's bed, and it was up to the individual resident whether or not they wanted to use them. She stated most recently, the facility has only been attaching them to beds for residents who are assessed for them and agree to them. When asked if side rails should be included on a resident's baseline care plan, RN #1 stated, "In my mind, they came on	F 655	The MDS coordinators, IDT and Licensed Nurses will be inserviced by the regional clinical nurse and/or the DON on the development and implementation of the baseline care plan as well as ensuring that the baseline care plan is accurate prior to providing care plan summary to the residents and/or Resident Representative. Monitoring: The MDS coordinators are responsible for maintaining compliance. The MDS coordinators and or DON/ADON will perform weekly chart audits of all new admissions for 12 weeks to ensure baseline care plans are being completed accurately, timey and that a written summary has been completed and reviewed with the resident and/or Resident Representative. Any negative findings will be reported to the MDS coordinator for correction. Detailed findings of the care plan audit will be reported to the QAPI committee for review monthly x 3 months for review, analysis and recommendations for change in facility policy, procedure and or practice.	

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F 655	Continued From page 29	F 655		

the beds when we opened this building. If they didn't need them, they didn't use them." She added if it does not impede the resident's functioning, it is not a restraint. "They are not something I would think needed to be on the care plan." When asked who develops the baseline care plan, RN #1 stated that on admission, the MDS nurse or the floor nurse initiates the care plan.

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

A review of the facility policy, "Comprehensive Care Planning," revealed, in part: "An "Interim" Baseline Care plan must be developed within 48 hours of admission to insure that the resident's needs are met appropriately until the Comprehensive Care Plan is completed."

No further information was provided prior to exit.

2. Resident #69 was admitted to the facility on 7/14/21 with diagnoses including endocarditis (1), COPD (chronic obstructive pulmonary disease) (2), and dementia (3). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/26/21, Resident #69 was coded as being moderately cognitively impaired for making daily decisions. He was coded as requiring the assistance of two staff members for bed mobility and transfers.

On the following dates and times: 8/3/21 at 12:36

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p.m. and 3:45 p.m.; 8/4/21 at 9:49 a.m., observations revealed, Resident #69 was observed lying in bed. At each of these observations, bilateral side rails were up at the head of the resident's bed.

A review of Resident #69's clinical record revealed a Side Rail Evaluation form dated 7/20/21. The form documented the resident's assessment for the use of side rails, the explanation of risks and benefits, and the date of informed consent for the use of the side rails.

A review of Resident #69's baseline care plan dated 7/21/21 revealed no evidence of any information related to his use of side rails.

On 8/4/21 at 12:53 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if side rails should be included on a resident's care plan, LPN #2 stated, "Yes, if it is necessary for resident safety, it should be care planned."

On 8/4/21 at 3:15 p.m., RN (registered nurse) #1, the MDS nurse, was interviewed. When asked if side rails should be included on a resident's baseline care plan, RN #1 stated the facility used to put side rails on every resident's bed, and it was up to the individual resident whether or not they wanted to use them. She stated most recently, the facility has only been attaching them to beds for residents who are assessed for them and agree to them. When asked if side rails should be included on a resident's baseline care plan, RN #1 stated, "In my mind, they came on the beds when we opened this building. If they didn't need them, they didn't use them." She added if it does not impede the resident's functioning, it is not a restraint. "They are not

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F 655	Continued From page 31	F 655		

something I would think needed to be on the care plan." When asked who develops the baseline care plan, RN #1 stated that on admission, the MDS nurse or the floor nurse initiates the care plan.

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

No further information was provided prior to exit.

REFERENCES
(1) "Infectious endocarditis is the inflammation of the endocardium, the inner lining of the heart, as well as the valves that separate each of the four chambers within the heart. It is primarily a disease caused by bacteria and has a wide array of manifestations and sequelae." This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK557641/.

(2) COPD is "a general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

(3) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.

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F 656	Continued From page 32	F 656		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		9/10/21

§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 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

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F 656	Continued From page 33 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 observation, resident interviews, staff interviews, clinical record reviews and facility document reviews it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for eight of 37 residents in the survey sample, (Residents #58, #6, #17, #48, #67, #28, #53 and #29). The findings include: 1. The facility staff failed to implement Resident #58's comprehensive pain care plan for the use of non-pharmacological interventions prior to the administration of as needed pain medication. Resident #58 was admitted to the facility with diagnoses that included but were not limited to encephalopathy (1) and cirrhosis of the liver (2). Resident #58's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/18/2021, coded Resident #58 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Section J coded Resident #58 receiving scheduled and as needed pain medications. Section J further coded Resident #58 not receiving non-medication interventions for pain and having pain almost constantly. On 8/3/2021 at approximately 4:15 p.m., an	F 656	Corrective Action(s): Resident #17 has expired. Resident #53, #67, #28, #6, and #48's care plans were updated to include the use of quarter rails. Resident #29's care plans was updated to include a fall mat at right side of bed while in bed. Resident #58's PRN pain medication has been discontinued. Identification of Deficient Practice(s) & Corrective Action(s): A 100% audit of current comprehensive care plans will be conducted by the MDS Coordinators, Unit Mangers, DON and/or ADON to identify residents with inaccurate or incomplete comprehensive care plans. Any negative findings will be corrected at time of discovery. Systemic Change(s): The comprehensive care plan policy has been reviewed and no changes are warranted at this time. The IDT will be inserviced by regional clinical nurse and/or the DON on the development, implementation and revision of comprehensive care plans on admission, quarterly and as needed with significant change is status. Monitoring: The MDS coordinators will audit 4	

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interview was conducted with Resident #58 in their room. When asked about pain management, Resident #58 stated that pain medications had to be requested to the nurses when needed. Resident #58 stated that the nurses assessed his pain by asking him what number his pain was and provided the medication. When asked if staff attempt or offer non-pharmacological interventions prior to administering the medication, Resident #58 stated that they just gave him the medication.

The comprehensive care plan for Resident #58 dated 7/13/2021 documented in part, "Resident has reported episodes of pain with potential for further pain. Date Initiated: 07/13/2021. Revision Date: 07/27/2021..." Under "Interventions/Tasks" it documented in part, "...Implement non pharmacological interventions to release the pain like Distraction techniques, relaxation and breathing exercises, music therapy, re-position. Date Initiated: 07/13/2021; Revision on: 07/27/2021..."

The physician orders for Resident #58 documented in part,
- "oxyCODONE HCL [hydrochloride] Tablet 5 MG, Give 2 (two) tablet by mouth every 4 (four) hours as needed for pain. Order Date: 07/13/2021. End Date: 07/16/2021."
- "Dilaudid Tablet 2 MG (milligram) (HYDROmorphone HCL) Give 1 (one) tablet by mouth every 4 (four) hours as needed for pain. Order Date: 07/16/2021."

The eMAR (electronic medication administration record) dated 7/1/2021-7/31/2021 documented the Oxycodone administered to Resident #58 on 7/13/2021 at 4:08 p.m. for a pain level of seven,

resident's care plans weekly coinciding with the care plan calendar x 12 weeks to monitor for compliance. Any negative findings will be corrected at time of discovery and the results of the audits will be forwarded to the DON or designee. Audit findings will be reported to QAPI communities monthly x 3 months for further review and recommendations.

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on 7/14/2021 at 4:02 p.m. for a pain level of seven and on 7/16/2021 at 1:39 a.m. for a pain level of seven.

The eMAR dated 7/1/2021-7/31/2021 documented the Dilaudid administered to Resident #58 on 7/17/2021 at 6:20 a.m. for a pain level of five and at 12:13 p.m. for a pain level of five. The eMAR further documented Resident #58 receiving the Dilaudid on 7/18/2021 at 12:10 p.m. for a pain level of eight, on 7/20/21 at 8:38 p.m. for a pain level of eight, on 7/22/21 at 1:23 a.m. for a pain level of eight and on 7/26/21 at 9:52 a.m. for a pain level of five.

The eMAR dated 7/1/2021-7/31/2021 failed to evidence documentation of non-pharmacological interventions prior to the administration of the as needed pain medication on the dates and times listed above.

The progress notes for Resident #58 failed to evidence documentation of non-pharmacological interventions prior to the administration of the as needed pain medication on the dates and times listed above.

On 8/4/2021 at approximately 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the care plan gives an idea of a resident's needs and how to take care of them. LPN #2 stated that nursing was responsible for ensuring that the care plan was followed.

On 8/5/2021 at approximately 8:35 a.m., an interview was conducted with LPN #5, unit manager. LPN #5 stated that when a resident complained of pain they assessed the resident to

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determine the level of pain and the possible cause of the pain. LPN #5 stated that interventions other than medication were attempted first to see if they could relieve the pain. LPN #5 stated that if the non-pharmacological interventions were not successful in relieving the pain, then they would administer the ordered pain medication. LPN #5 stated that this was to minimize the amount of medications administered to the resident unless needed. LPN #5 stated that they utilized non-pharmacological interventions such as relaxation techniques, turning and repositioning to attempt to relieve pain. LPN #5 stated that non-pharmacological interventions were documented on the eMAR (electronic medication administration record) or in the nurses' notes. LPN #5 reviewed the eMAR for Resident #58 dated 7/1/2021-7/31/2021 and progress notes and stated that they did not see documentation that non-pharmacological interventions were attempted prior to the administration of the as needed pain medications documented above. LPN #5 stated that staff were not implementing Resident #58's care plan if non-pharmacological interventions were not attempted.

On 8/5/2021 at approximately 9:20 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that staff were expected to implement non-pharmacological interventions like turning and repositioning or offering a cold pack prior to administering as needed pain medications. ASM #2 stated that staff were expected to document the non-pharmacological interventions with their effectiveness in the nurses' notes. ASM #2 was asked to provide evidence of staff offering/implementing non-pharmacological

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interventions prior to the administration of the as needed pain medications as listed above.

On 8/5/2021 at approximately 10:10 a.m., ASM #2 stated that there were no non-pharmacological interventions documented for Resident #58 on the dates/times listed above.

On 8/3/2021 at approximately 2:30 p.m., ASM #1, the administrator, provided a title page from the Lippincott Manual of Nursing Practice, Eleventh Edition via email as their nursing standard of practice requested upon survey entrance.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..."

On 8/5/2021 at approximately 11:00 a.m., a request was made to ASM #1 for the facility policy on developing and implementing the care plan.

The facility policy "Comprehensive Care Planning" dated 7/19/2019 documented in part, "An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis..." The policy further documented, "...All direct care staff

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must always know, understand and follow their Resident's Care Plan. If unable to implement any part of the plan, notify your Charge Nurse or MDS Coordinator, so that this can be documented or the Care Plan changed if necessary..."

On 8/5/2021 at approximately 11:30 a.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3 the regional vice president of operations were made aware of the concern. No further information was provided prior to exit.

References:

1. "Encephalopathy is a general term describing a disease that affects the function or structure of your brain." This information is taken from the website https://www.healthline.com/health/hepatic-encephalopathy.

2. "Cirrhosis is scarring of the liver. Scar tissue forms because of injury or long-term disease. Scar tissue cannot do what healthy liver tissue does - make protein, help fight infections, clean the blood, help digest food and store energy." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=cirrhosis&_ga=2.73159383.513196122.1626311381-1838772440.1562936034

2. The facility staff failed to develop and implement a comprehensive care plan for the use of side rails for Resident #6.

Resident #6 was admitted to the facility with

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diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD) (1) and dysphagia (2).

Resident #6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/28/2021, coded Resident #6 as scoring a 9 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 9- being moderately impaired for making daily decisions. Section G coded Resident #6 requiring extensive assistance from two staff members for bed mobility and extensive assistance of one staff member for transfers, toilet use and personal hygiene.

On 8/3/2021 at approximately 1:10 p.m., an observation was made of Resident #6 in bed eating lunch. Resident #6 was observed lying in bed with bilateral upper side rails in place. At this time, an interview was conducted with Resident #6. Resident #6 stated that he used the side rails on the bed to assist him to turn and move up in the bed.

Additional observations on 8/3/2021 at 4:00 p.m. and 8/4/2021 at 8:45 a.m. revealed the bilateral side rails in place and Resident #6 in bed.

The comprehensive care plan for Resident #6 dated 4/8/2021 documented in part, "Resident has self-care deficit. Date Initiated: 04/08/2021..." The care plan failed to evidence a documentation for the use of side rails.

The physician order's for Resident #6 failed to evidence an order for the use of side rails.

The document, "Evaluation for use of Side Rails"

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for Resident #6 dated 7/20/2021 documented in part, "...Side rail(s) are recommended at all times when resident is in bed. Side rail precautions have been discussed with Resident, Family/Resident Representative. Alternatives to side rails have been discussed with Resident, Family, Resident representative..."

On 8/4/2021 at approximately 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the care plan gives an idea of a resident's needs and how to take care of them. LPN #2 stated that nursing was responsible for ensuring that the care plan was followed. LPN #2 stated that side rails should be on the care plan because they were necessary for resident safety.

On 8/4/21 at 3:15 p.m., an interview was conducted with RN (registered nurse) #1, MDS (minimum data set) coordinator, regarding the purpose of the care plan and if care plans should be reviewed and revised for the use of bed rails. RN #1 stated, "Purpose of care plan is to let staff know how to care for them...Most recently we are having orders for them [bed rails/side rails], they came on the beds when we got them, so we didn't always have orders. I'm not going to guarantee that bed rails are on every care plan. We update the care plan when there is a change. I don't necessarily know to add the bedrails. If the bedrails are not on the care plan, it should be on the kardex."

On 8/4/21 at 3:57 p.m., an interview was conducted with LPN #1 regarding the purpose of the care plan. LPN #1 stated, "To let you know what the residents' needs are, how you meet their goals." LPN #1 stated bed rails are used to assist

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residents with turning and repositioning and the use of bed rails should be care planned because the use is something nurses have to keep re-assessing, for safety and to see if there is a continued need for the bed rails.

On 8/5/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations were notified of the findings. No further information was provided prior to exit.

References:

1. Chronic obstructive pulmonary disease (COPD): Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. Dysphagia: A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html

3. The facility staff failed to develop and implement a comprehensive care plan for the use of side rails for Resident #17.

Resident #17 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD) (1) and atrial fibrillation (2).

Resident #17's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/8/2021, coded

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Resident #17 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Section G coded Resident #6 requiring extensive assistance from two staff members for bed mobility, transfers and toilet use.

On 8/3/2021 at approximately 1:20 p.m., an observation was made of Resident #17 in bed with bilateral upper side rails in place. At this time, an interview was attempted with Resident #17. Resident #17 did not answer appropriately when asked about the side rails.

Additional observations on 8/3/2021 at 4:05 p.m. and 8/4/2021 at 8:30 a.m. revealed the bilateral side rails in place and Resident #17 in bed.

The comprehensive care plan for Resident #17 dated 6/3/2021 documented in part, "Resident has self-care deficit. Date Initiated: 06/03/2021..." The care plan failed to evidence documentation addressing the use of side rails.

The physician order's for Resident #17 failed to evidence an order for the use of side rails.

The document, "Saber Bed Rail Assessment" dated 6/2/2021 for Resident #17 documented in part, "...to assist in repositioning...Informed consent obtained from resident/resident representative..."

On 8/4/2021 at approximately 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the care plan gives an idea of a resident's needs and how to take care of them. LPN #2 stated that nursing

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was responsible for ensuring that the care plan was followed. LPN #2 stated that side rails should be on the care plan because they were necessary for resident safety.

On 8/4/21 at 3:15 p.m., an interview was conducted with RN (registered nurse) #1, MDS (minimum data set) coordinator, regarding the purpose of the care plan and if care plans should be reviewed and revised for the use of bed rails. RN #1 stated, "Purpose of care plan is to let staff know how to care for them...Most recently we are having orders for them [bed rails/side rails], they came on the beds when we got them, so we didn't always have orders. I'm not going to guarantee that bed rails are on every care plan. We update the care plan when there is a change. I don't necessarily know to add the bedrails. If the bedrails are not on the care plan, it should be on the kardex."

On 8/4/21 at 3:57 p.m., an interview was conducted with LPN #1 regarding the purpose of the care plan. LPN #1 stated, "To let you know what the residents' needs are, how you meet their goals." LPN #1 stated bed rails are used to assist residents with turning and repositioning and the use of bed rails should be care planned because the use is something nurses have to keep re-assessing, for safety and to see if there is a continued need for the bed rails.

On 8/5/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations were notified of the findings. No further information was provided prior to exit.

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References:

1. Chronic obstructive pulmonary disease (COPD): Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

2. Atrial fibrillation: A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html>.

4. The facility staff failed to develop and implement a comprehensive care plan for the use of side rails for Resident #48.

Resident #48 was admitted to the facility with diagnoses that included but were not limited to dysphagia (1) and dementia (2).

Resident #48's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/2021, coded Resident #48 as scoring a 4 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 4- being severely impaired for making daily decisions. Section G coded Resident #48 requiring extensive assistance from two staff members for bed mobility and totally dependent of one staff member for toileting and personal hygiene.

On 8/4/2021 at approximately 8:30 a.m., an observation was made of Resident #48 in bed with bilateral upper side rails in place.

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Additional observations on 8/4/2021 at 11:30 a.m. and 2:00 p.m. revealed the bilateral side rails in place and Resident #48 in bed.

The comprehensive care plan for Resident #48 dated 4/8/2021 documented in part, "Resident has self-care deficit. Date Initiated: 04/08/2021..." The care plan failed to evidence documentation addressing the use of side rails.

The physician order's for Resident #48 failed to evidence an order for the use of side rails.

The document, "Saber Bed Rail Assessment" dated 7/23/2021 for Resident #48 documented in part, "...mobility...Informed consent obtained from resident/resident representative..."

On 8/4/2021 at approximately 1:00 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that the care plan gives an idea of a resident's needs and how to take care of them. LPN #2 stated that nursing was responsible for ensuring that the care plan was followed. LPN #2 stated that side rails should be on the care plan because they were necessary for resident safety.

On 8/4/21 at 3:15 p.m., an interview was conducted with RN (registered nurse) #1, MDS (minimum data set) coordinator, regarding the purpose of the care plan and if care plans should be reviewed and revised for the use of bed rails. RN #1 stated, "Purpose of care plan is to let staff know how to care for them...Most recently we are having orders for them [bed rails/side rails], they came on the beds when we got them, so we didn't always have orders. I'm not going to guarantee that bed rails are on every care plan.

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We update the care plan when there is a change. I don't necessarily know to add the bedrails. If the bedrails are not on the care plan, it should be on the kardex."

On 8/4/21 at 3:57 p.m., an interview was conducted with LPN #1 regarding the purpose of the care plan. LPN #1 stated, "To let you know what the residents' needs are, how you meet their goals." LPN #1 stated bed rails are used to assist residents with turning and repositioning and the use of bed rails should be care planned because the use is something nurses have to keep re-assessing, for safety and to see if there is a continued need for the bed rails.

On 8/5/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional vice president of operations were notified of the findings. No further information was provided prior to exit.

References

1. Dysphagia: A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.
5. The facility failed to develop a comprehensive care plan to address the use of bed rails for Resident #67.

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Resident #67 was admitted to the facility on 12/29/20. Resident #67s diagnoses included but were not limited to: Alzheimer's disease (progressive loss of mental ability and function often accompanied by personality changes) (1), fracture of left femur (break in left thighbone) (2) and degeneration of discs (physical decline that involves tissue and cellular changes of the cushioning tissue between the vertebrae) (3).

Resident #67's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/25/21, coded the resident as scoring 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview. MDS Section G- Functional Status: coded the resident, as extensive assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing; walking and locomotion did not occur. A review of MDS Section H- Bowel and Bladder: coded the resident as always incontinent for bowel and for bladder.

Resident #67 was observed in bed with bilateral side rails up on 8/3/21 at 11:30 AM and 8/4/21 at 8:05 AM.

A review of Resident #67's comprehensive care plan dated 12/21/20 and revised on 6/15/21, documents in part, "FOCUS-The resident has self-care deficit. INTERVENTIONS-Assist with activities of daily living, dressing, grooming, toileting, feeding and oral care. Evaluate needs for adaptive equipment." The comprehensive care plan failed to evidence documentation addressing the use of bed rails when reviewed 8/3/21 and 8/4/21.

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A review of Resident #67's comprehensive care plan on 8/5/21, documented in part, the following revision to the care plan on 8/4/21 "Two assist rails to bed."

An interview was conducted on 8/4/21 at 1:01 PM with LPN (Licensed practical nurse) #2 regarding the purpose of the comprehensive care plan. LPN #2 stated, "It gives you the idea of a resident's need and how to take care of them". When asked who is responsible for implementing care plan, LPN #2 stated, "The MDS coordinator is responsible, the care plan is updated/revised after significant change or based on progress notes". When asked who is responsible to make sure care plan is followed, LPN #2 stated, "Nursing is responsible for the care plan is followed." When asked if the side rails should be care planned, LPN #2 stated, "Yes, they should be. If it is necessary for resident safety, it should be care planned."

An interview was conducted on 8/04/21 at 3:15 PM with RN (registered nurse) #1, the MDS Coordinator regarding the purpose of the comprehensive care plan. RN #1 stated, "The purpose of care plan is to let staff know how to care for them. Generally, I would say not the bed rails are not considered a restraint because they are an assist bar. The bedrails came on the beds when we got them. I am not going to guarantee that bedrails are on every care plan. We update the care plan when there is a change. I don't necessarily know to add the bedrails."

On 8/05/21 at 11:30 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM, the regional VP of operations were informed of the concern.

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A review of the facility's "Comprehensive Care Plan" policy dated 7/19/19, documents in part, "The MDS Coordinator is to review the 24- Hour Report daily for significant changes or changes in resident's ADL status. The Care Planning Coordinator will add minor changes in resident's status to the existing Care Plans on daily basis."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 25.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 218/232.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 153.

6. The facility failed to develop a comprehensive care plan to address the use of bed rails for Resident #28.

Resident #28 was admitted to the facility on 9/16/20. Resident #28's diagnoses included but were not limited to: congestive heart failure (circulatory congestion and retention of salt and water by the kidneys) (4), aortic valve stenosis (narrowing or stricture of the aortic valve) (5) and lymphedema (accumulation of lymph in the tissues) (6).

Resident #28's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/21/21, coded the resident as scoring 99 out of 15 on the BIMS

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(brief interview for mental status) score, indicating the resident was unable to complete the interview. MDS Section G- Functional Status: coded the resident as extensive assistance with bed mobility, transfers, dressing, personal hygiene and bathing; eating required supervision and walking and locomotion did not occur. A review of MDS Section H- Bowel and Bladder: coded the resident as frequently incontinent for bowel and for bladder.

Resident #28 was observed in bed with bilateral side rails up on 8/3/21 at 11:20 AM and 8/4/21 at 8:00 AM.

A review of Resident #28's comprehensive care plan dated 6/16/21, documents in part, "FOCUS-The resident has self-care deficit. INTERVENTIONS-Assist with activities of daily living, dressing, grooming, toileting, feeding and oral care. Evaluate needs for adaptive equipment. Educate/direct the use of assistive devices. Promote independence; provide positive reinforcement for all activities attempted." The comprehensive care plan failed to evidence documentation addressing the use of bed rails reviewed on 8/3/21 and 8/4/21.

A review of Resident #28's comprehensive care plan on 8/5/21, documented in part, the following revision on 8/4/21 "Two assist rails to bed."

An interview was conducted on 8/4/21 at 1:01 PM with LPN (Licensed practical nurse) #2 regarding the purpose of the comprehensive care plan. LPN #2 stated, "It gives you the idea of a resident's need and how to take care of them". When asked who is responsible for implementing care plan, LPN #2 stated, "The MDS coordinator is

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responsible, the care plan is updated/revised after significant change or based on progress notes". When asked who is responsible to make sure care plan is followed, LPN #2 stated, "Nursing is responsible for the care plan is followed." When asked if the side rails should be care planned, LPN #2 stated, "Yes, they should be. If it is necessary for resident safety, it should be care planned."

An interview was conducted on 8/04/21 at 3:15 PM with RN (registered nurse) #1, the MDS Coordinator regarding the purpose of the comprehensive care plan. RN #1 stated, "The purpose of care plan is to let staff know how to care for them. Generally, I would say not the bed rails are not considered a restraint because they are an assist bar. The bedrails came on the beds when we got them. I am not going to guarantee that bedrails are on every care plan. We update the care plan when there is a change. I don't necessarily know to add the bedrails."

On 8/05/21 at 11:30 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM, the regional VP of operations were informed of the concern.

A review of the facility's "Comprehensive Care Plan" policy dated 7/19/19, documents in part, "The MDS Coordinator is to review the 24- Hour Report daily for significant changes or changes in resident's ADL status. The Care Planning Coordinator will add minor changes in resident's status to the existing Care Plans on daily basis."

No further information was provided prior to exit.

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References:

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(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 133.
(5) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 43.
(6) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 344.
7. The facility staff failed to develop a comprehensive care plan to address Resident #53's use of side rails.

Resident #53 was admitted to the facility on 7/9/21 with diagnoses including a shoulder infection and diabetes (1). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/15/21, Resident #53 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the extensive assistance of staff for bed mobility.

On the following dates and times: 8/3/21 at 1:02 p.m. and 4:02 p.m.; 8/4/21 at 9:55 a.m., Resident #53 was observed lying in his bed. At all observations, bilateral side rails were raised at the hood of the resident's bed.

A review of Resident #53's record revealed Side Rail Evaluation form dated 7/9/21. The form documented the resident's assessment for the use of side rails, the explanation of risks and benefits, and the date of informed consent for the use of the side rails.

A review of Resident #53's comprehensive care

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plan, dated 7/13/21 and updated 7/27/21, revealed no evidence of any information related to the use of side rails.

On 8/4/21 at 12:53 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked if side rails should be included on a resident's care plan, she stated: "Yes, if it is necessary for resident safety, it should be care planned."

On 8/4/21 at 3:15 p.m., RN (registered nurse) #1, the MDS nurse, was interviewed. Shen asked if side rails should be included on a resident's care plan, she stated the facility used to put side rails on every resident's bed, and it was up to the individual resident whether or not they wanted to use them. RN #1 stated most recently, the facility has only been attaching them to beds for residents who are assessed for them and agree to them. When asked if side rails should be included on a resident's baseline care plan, RN #1 stated, "In my mind, they came on the beds when we opened this building. If they didn't need them, they didn't use them." She added if it does not impede the resident's functioning, it is not a restraint. "They are not something I would think needed to be on the care plan."

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

No further information was provided prior to exit.

REFERENCES
(1) "Diabetes (mellitus) is a disease in which your

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blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

8. The facility staff failed to implement Resident #29's comprehensive care plan to place the residents call bell within reach and to place fall mats beside the resident's bed.

Resident #29 was admitted to the facility on 6/21/21 with diagnoses including dementia (1) and bipolar disorder (2). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/22/21, Resident #29 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). She was coded as having had a fall in the month prior to admission, and as having had no falls since admission to the facility.

On the following dates and times: 8/3/21 at 12:47 p.m. and 4:00 p.m.; 8/4/21 at 9:53 a.m., Resident #29 was observed lying in bed. At each observation, the resident's call bell was lying on the floor behind the head of her bed, and no fall mats were observed on the floor beside her bed.

A review of Resident #29's clinical record revealed she had sustained falls without injury on 7/1/21, 7/2/21, and 7/21/21.

A review of Resident #29's comprehensive care plan, dated 6/22/21 and updated 7/22/21, revealed, in part: "Minimize risks for falls/minimize injuries related to falls: "Fall mat to

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right side of bed...Implement preventative fall interventions/devices...Maintain call light within reach. Educate resident to use call light."

On 8/4/21 at 12:53 p.m., LPN (licensed practical nurse) # 2 was interviewed regarding the purpose of a care plan. LPN #2 stated it gives you an idea of the resident's needs and how to take care of the residents. She stated the MDS nurse has a part in making sure the care plan gets implemented. She also said nurses are responsible for implementing the care plan. She stated the DON (director of nursing) and the unit managers tell nurses if any new interventions have been added to the care plan.

On 8/4/21 at 3:15 p.m., RN (registered nurse) #1, the MDS nurse, was interviewed. When asked the purpose of the care plan, RN #1 stated, "So we know how to take care of the resident."

On 8/4/21 at 3:44 p.m., RN (registered nurse) #3 was interviewed. When asked how makes certain fall prevention interventions are implemented, RN #3 stated it is all staff's responsibility. She stated fall prevention measures are usually listed on the care plan. She stated any updates or changes to the care plan are passed along in report, and she passes this information along to CNAs and other staff who are caring for a resident. She stated fall prevention measures help lessen the chance for a resident sustaining injury.

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

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F 656	Continued From page 56 On 8/5/21 at 8:43 a.m., CNA #5 was interviewed. When asked where a resident's call bell should be located, she stated it should be located within a resident's reach. When asked if she is aware of any fall prevention interventions on Resident #29's care plan, she stated she would have to check with the nurse. When asked who is responsible for making sure fall prevention interventions are in place for residents, CNA #5 stated, "I am. And I guess all of us." No further information was provided prior to exit. REFERENCES (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (2) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		9/10/21

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F 657	Continued From page 57 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for four of 37 residents in the survey sample, Residents #31, #25, #37 and #21. The findings include: 1. The facility staff failed to review and revise Resident #31's comprehensive care plan for the use of bed rails. Resident #31 was admitted to the facility on 1/3/20. Resident #31's diagnoses included but	F 657	Corrective Action(s): Resident #25 is no longer in facility. Residents #21, #31 and #37 have had their care plans reviewed and revised to include the use of quarter rails while in bed. Identification of Deficient Practice(s)& Corrective Action(s): A 100% review of all current comprehensive care plans will be conducted by the MDS coordinators and/or DON/ADON to identify residents it inaccurate or incomplete care plans. Any negative findings will be corrected at time	

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F 657	Continued From page 58 were not limited to stroke, chronic kidney disease and anxiety disorder. Resident #31's quarterly minimum data set assessment with an assessment reference date of 6/23/21, coded the resident's cognition as severely impaired. Review of Resident #31's clinical record revealed a bed rail assessment dated 5/17/21 that documented the resident had not shown any clinical need for side rails (bed rails) at that time. On 8/3/21 at 11:22 a.m. and 8/4/21 at 8:01 a.m., Resident #31 was observed in bed with bilateral U bar bed rails. Review of Resident #31's comprehensive care plan initiated on 1/6/20 failed to reveal documentation regarding the use of bed rails. On 8/4/21 at 3:15 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS [minimum data set] coordinator) regarding the purpose of the comprehensive care plan and if comprehensive care plans should be reviewed and revised for the use of bed rails. RN #1 stated, "Purpose of care plan is to let staff know how to care for them...Most recently we are having orders for them [bed rails], they came on the beds when we got them, so we didn't always have orders. I'm not going to guarantee that bed rails are on every care plan. We update the care plan when there is a change. I don't necessarily know to add the bedrails. If the bedrails are not on the care plan, it should be on the kardex." On 8/4/21 at 3:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding the purpose of the care plan. LPN #1 stated, "To let you know what the residents' needs	F 657	of discovery. Systemic Change(s): The regional clinical nurse and/or the DON will provide inservice training to the IDT team on the requirement to develop and implement a comprehensive care plan and to review and revise each residents care plan as indicated by any resident change in condition or changes to care requirements. Monitoring: The IDT team will audit Comprehensive Care Plans weekly coinciding with the care plan calendar for 12 weeks to monitor for compliance. Any negative findings or significant change will be reported to the DON and/or MDS Coordinator for care plan correction. Audit findings will be reported to the QAPI committee monthly for review and recommendations x 3 months.	

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are, how you meet their goals." LPN #1 stated bed rails are used to assist residents with turning and repositioning and the use of bed rails should be care planned because the use is something nurses have to keep re-assessing, for safety and to see if there is a continued need for the bed rails.

On 8/4/21 at 5:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility policy titled, "Comprehensive Care Planning" documented, "An interdisciplinary plan of care will be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis."

2. The facility staff failed to review and revise Resident #25's comprehensive care plan for the use of bed rails.

Resident #25 was admitted to the facility on 6/14/21. Resident #25's diagnoses included but were not limited to muscle weakness, chronic kidney disease and pneumonia. Resident #25's admission minimum data set assessment with an assessment reference date of 6/20/21, coded the resident's cognition as severely impaired.

Review of Resident #25's clinical record revealed a bed rail assessment dated 6/14/21 that documented bed rails were needed for assistance with mobility.

On 8/3/21 at 12:47 p.m. and 8/3/21 at 4:42 p.m., Resident #25 was observed in bed with bilateral

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U bar bed rails.

Review of Resident #25's comprehensive care plan initiated on 6/17/21 failed to reveal documentation regarding the use of bed rails.

On 8/4/21 at 3:15 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS [minimum data set] coordinator) regarding the purpose of the care plan and if care plans should be reviewed and revised for the use of bed rails. RN #1 stated, "Purpose of care plan is to let staff know how to care for them...Most recently we are having orders for them [bed rails], they came on the beds when we got them, so we didn't always have orders. I'm not going to guarantee that bed rails are on every care plan. We update the care plan when there is a change. I don't necessarily know to add the bedrails. If the bedrails are not on the care plan, it should be on the kardex."

On 8/4/21 at 3:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding the purpose of the care plan. LPN #1 stated, "To let you know what the residents' needs are, how you meet their goals." LPN #1 stated bed rails are used to assist residents with turning and repositioning and the use of bed rails should be care planned because the use is something nurses have to keep re-assessing, for safety and to see if there is a continued need for the bed rails.

On 8/4/21 at 5:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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3. The facility staff failed to review and revise Resident #37's comprehensive care plan for the use of bed rails.

Resident #37 was admitted to the facility on 5/28/19. Resident #37's diagnoses included but were not limited to convulsions, major depressive disorder and high blood pressure. Resident #37's quarterly minimum data set assessment with an assessment reference date of 7/2/21, coded the resident's cognitive skills for daily decision making as severely impaired.

Review of Resident #37's clinical record revealed a bed rail assessment dated 6/2/21 that documented bed rails were needed for turning and repositioning.
On 8/3/21 at 11:29 a.m. and 8/4/21 at 8:03 a.m., Resident #37 was observed in bed with bilateral U bar bed rails.

Review of Resident #37's comprehensive care plan initiated on 7/22/20 failed to reveal documentation regarding the use of bed rails.

On 8/4/21 at 3:15 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS [minimum data set] coordinator) regarding the purpose of the care plan and if care plans should be reviewed and revised for the use of bed rails. RN #1 stated, "Purpose of care plan is to let staff know how to care for them...Most recently we are having orders for them [bed rails], they came on the beds when we got them, so we didn't always have orders. I'm not going to guarantee that bed rails are on every care plan. We update the care plan when there is a change. I don't necessarily know to add the bedrails. If the bedrails are not on the care plan, it should be

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on the kardex."

On 8/4/21 at 3:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding the purpose of the care plan. LPN #1 stated, "To let you know what the residents' needs are, how you meet their goals." LPN #1 stated bed rails are used to assist residents with turning and repositioning and the use of bed rails should be care planned because the use is something nurses have to keep re-assessing, for safety and to see if there is a continued need for the bed rails.

On 8/4/21 at 5:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

4. The facility staff failed to review and revise Resident #21's comprehensive care plan for the use of bed rails.

Resident #21 was admitted to the facility on 5/27/20. Resident #21's diagnoses included but were not limited to high blood pressure, chronic respiratory failure and pain. Resident #21's quarterly minimum data set assessment with an assessment reference date of 6/12/21, failed to code the resident's cognition.

Review of Resident #21's clinical record revealed a bed rail assessment dated 11/17/20 that documented bed rails were needed for impaired mobility.
On 8/3/21 at 11:27 a.m. and 8/4/21 at 8:03 a.m., Resident #21 was observed in bed with bilateral U bar bed rails.

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F 657	Continued From page 63 Review of Resident #21's comprehensive care plan initiated on 5/28/20 failed to reveal documentation regarding the use of bed rails. On 8/4/21 at 3:15 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS [minimum data set] coordinator) regarding the purpose of the care plan and if care plans should be reviewed and revised for the use of bed rails. RN #1 stated, "Purpose of care plan is to let staff know how to care for them...Most recently we are having orders for them [bed rails], they came on the beds when we got them, so we didn't always have orders. I'm not going to guarantee that bed rails are on every care plan. We update the care plan when there is a change. I don't necessarily know to add the bedrails. If the bedrails are not on the care plan, it should be on the kardex." On 8/4/21 at 3:57 p.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding the purpose of the care plan. LPN #1 stated, "To let you know what the residents' needs are, how you meet their goals." LPN #1 stated bed rails are used to assist residents with turning and repositioning and the use of bed rails should be care planned because the use is something nurses have to keep re-assessing, for safety and to see if there is a continued need for the bed rails. On 8/4/21 at 5:01 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 657		
F 675 SS=D	Quality of Life CFR(s): 483.24	F 675		9/10/21

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F 675	Continued From page 64 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, family interview, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services to promote a resident's quality of life for one of 37 residents in the survey sample, Resident #59. The facility staff failed to get Resident #59 out of bed into a chair from her admission on 7/13/21 through 8/3/21. The findings include: Resident #59 was admitted to the facility on 7/13/21 with diagnoses including history of a heart attack and heart failure. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/19/21, Resident #59 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the assistance of two staff members for bed mobility. She was coded as not having transferred from her bed to any other surface during the look back period. She was coded as not having normally used any mobility	F 675	Corrective Action(s): Resident #59 has been assessed and cleared by their attending physician to be up out of bed daily to a wheeled recliner as tolerated by resident. Resident #59 has been screened by therapy for the appropriate transfer method to be used to transfer her out of bed and into recliner each day. Resident #59's care plan has been revised to update her transfer and mobility status. Identification of Deficient Practice(s) & Corrective Action(s): All current residents coded as spending all or most of their time in bed on the most recent MDS may have been potentially affected. A 100% audit of all residents coded for spending all or most of their time in bed will be completed to identify residents at risk. Residents identified at risk will be reassessed by their attending physician and therapy to determined their level of mobility and their ability to be out of bed safely. Their comprehensive plans of care will be updated to reflect each	

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F 675	Continued From page 65 devices during the look back period. On the following dates and times: 8/3/21 at 12:22 p.m. and 3:48 p.m.; 8/4/21 at 9:48 a.m. and 4:05 p.m., observations revealed Resident #59 lying in bed with her eyes closed. On 8/3/21 at 12:22 p.m., Resident #59's daughter was interviewed. She stated she is concerned that Resident #59 has not been out of bed in a chair since her admission to the facility. She stated she and her sister are with the resident each day from approximately 9:00 a.m. until approximately 5:30 p.m. She stated neither she nor her sister had seen their mother up in a chair. She stated she told a staff member last week that she wanted to wash her mother's hair. She stated the staff member told her that her mother is too weak to get out of bed, and that the therapy staff had told the nursing staff that Resident #59 should remain in bed at all times. Resident #59's daughter could not recall which specific staff member with which she had spoken. She stated she managed to wash her mother's hair while her mother was lying in bed, but noted it was "really hard." She stated her mother had been ambulatory for brief times each day before her heart attack. She stated her mother loves flowers, and she would just love for her mother to be able to be in a chair of some kind and be rolled to the bed room window to see the beautiful flowers in the facility's courtyard. A review of Resident #59's clinical record contained no physician's orders regarding the resident's ability to get out of bed. A review of Resident #59's Physical Therapy Discharge Summary dated 7/28/21 revealed, in	F 675	resident's specific needs. Systemic Change(s): The facility policy and procedure has been reviewed and no revisions are warranted at this time. The DON and/or ADON will in-service all nursing staff, to include agency staff and new hires on the expectation that all residents are to be out of bed daily unless medically contradicted or the resident chooses to stay in bed. Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform new admission chart audits weekly x 12 weeks to ensure the residents mobility level and activity level are addressed at time of admission to monitor for compliance. Any/all negative findings will be corrected at time of discovery. Audit findings will be reported to QAPI committee monthly for 3 moths for review, analysis and recommendations for change in facility policy, procedure, and/or practice.	

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part: "D/C (discharge) reason: Highest Practical Level Achieved...Prognosis to Maintain CLOF (current level of functioning) = Good with consistent staff follow-through....Functional Bed Mobility = Max (maximum) A (assistance); Transfers = Max A; Level Surfaces = Total Dependence w/o (without) attempts to initiate; W/C (wheelchair) mobility + DNT (did not try)...Discharge Recommendations: 24 hour care."

A review of Resident #59's CNA (certified nursing assistant) POC (point of care charting) revealed no evidence that Resident #59 had been out of bed since her admission on 7/13/21.

A review of Resident #59's baseline care plan dated 7/14/21, revealed, in part: "Assist with activities of daily living, dressing, grooming, toileting, feeding, oral care... [Resident #59] enjoys spending time with her family. In the past she enjoyed oil painting, quilting, and working in her vegetable garden... [Resident #59] will participate in activities of interest over the next 90 days...Assist to and from activities of interest."

On 8/4/21 at 12:53 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked how the nursing staff knows how to transfer a new resident, or if a new resident is safe for transfer, LPN #2 stated she communicates with the CNAs (certified nursing assistants) to determine their comfort level with transferring a resident safely. She stated if the nursing staff is not comfortable transferring a resident, they will ask someone from therapy to come and help them. She stated every resident should be up in a chair out of bed every day unless a physician's order states otherwise. She stated sometimes the nursing

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staff asks therapy to evaluate a resident before they ever even try to move them. She stated this is true primarily for residents who have had joint replacement surgery.

On 8/4/21 at 2:31 p.m., OSM (other staff member) #8, a physical therapist, was interviewed. When asked therapy's role with determining a newly admitted resident's transfer status, OSM #8 stated she gets an order to evaluate the resident, and reviews the chart, including history, hospital records, and any other pertinent information. She stated she goes to assess the resident. She stated she talks with the resident about their goals. When asked about Resident #59's therapy course, OSM #8 stated Resident #59 came in from the hospital with significant hear failure after a heart attack. She stated the resident is 101 years old, and her family wanted her to have aggressive care and therapy. She stated the resident required maximum assistance for bed mobility and transfers. She stated when worked with therapy between 7/14/21 and 7/28/21. OSM #8 stated Resident #59 was discharged because she had met her maximum therapy potential. She stated the resident's main impediments to improvement were weakness and fatigue. When asked if she ever got Resident #59 out of bed, she stated she did not. She stated she assisted the resident to sit on the side of the bed, but the resident did not have stamina to sit for more than 10 or 15 minutes. When asked if she communicated with staff about transferring Resident #59 out of bed and into a chair, OSM #8 stated she told staff members to use a mechanical lift to move the resident from bed to a chair. She stated she told staff the resident needed to be supervised at all times when she was out of bed. She stated she

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had not worked with Resident #59 since 7/28/21, and no staff members had asked for her assistance with the resident since that date.

On 8/4/21 at 3:44 p.m., RN (registered nurse) #3 was interviewed. When asked if she is familiar with the care of Resident #59, she stated she is. When asked if she has ever seen Resident #59 out of bed, or if she has ever assisted another staff member to get Resident #59 out of bed, RN #3 stated she has not. RN #3 stated, "I don't think I have ever seen her out of bed." She stated she did not know any reason why the resident had not been out of bed. She stated Resident #59's family is "very involved." She stated if the resident has not been getting out of bed, it must be because that is the family's choice. RN #3 stated it is nursing's responsibility to make sure resident's get out of bed especially once therapy has stopped working with them. When asked if Resident #59's quality of life could be improved by getting out of bed into a rolling recliner for a few minutes each day so she could see flowers outside, RN #3 stated, "Yes."

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns. Evidence that Resident #59 had been out of bed since her admission on 7/13/21 was requested. Facility policies related to quality of life and getting residents out of bed were requested. ASM #1 stated the facility does not have a policy regarding getting residents out of bed.

On 8/5/21 at 8:19 a.m., ASM #2 was interviewed. When asked if the facility staff had located any

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evidence that Resident #59 had been out of bed since her admission, ASM #2 stated, "Only the therapy note." She stated ASM #5, the nurse practitioner, would be able to speak more to this concern.

On 8/5/21 at 8:43 a.m., CNA #5 was interviewed. She stated if a resident is new to her, she checks with the nurse about the resident's transfer status. She stated all residents need to be out of the bed and in a chair if they are able to be transferred. When asked whether she had ever gotten Resident #59 out of bed into a chair, CNA #5 stated the last time therapy tried to get her out of bed, the therapy staff said the resident was "a little weak." She stated when therapy says that, she does not try to get the resident up for safety reasons. She stated she had never gotten the resident out of bed during any of her day shifts. When asked if Resident #59's quality of life could be improved by getting out of bed into a rolling recliner for a few minutes each day so she could see flowers outside, CNA #5 stated, "Absolutely."

On 8/5/21 at 10:06 a.m., OSM #8 was interviewed. When asked why the therapy discharge summary referenced above does not contain written instructions for the staff, OSM #8 stated, "I verbalized it to a CNA, and the nurse working the hall." She stated she has frequent communication with nursing staff, and she remembers telling the CNA and the nurse that the resident could be transferred using a mechanical lift, and placed into a reclining wheelchair. When asked if Resident #59 is safe to transfer, OSM #8 stated, "Her family wants her to be up in the chair." She stated she has not transferred the resident into a rolling recliner because that is not something she assesses a resident's ability to do.

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F 675	Continued From page 70 OSM #8 stated, "She needs maximum assistance." On 8/5/21 at 11:21 a.m., ASM #5, the NP (nurse practitioner) was interviewed. She stated the nursing staff asked her about getting the resident out of bed on the previous afternoon (8/4/21). ASM #5 stated, "The staff is scared to get her up. They haven't even tried to get her up." She stated the staff at this facility ordinarily needs an order because they are very "task oriented," so she wrote an order last evening for the staff to get the resident out of bed. She stated the resident's daughter has told her multiple times that the staff says they cannot get the resident out of bed, and that they have not tried. When asked if Resident #59's quality of life could be improved by getting out of bed into a rolling recliner for a few minutes each day so she could see flowers outside, ASM #5 stated, "I would think so. Yes." A review of the facility-provided policy, "Life Enrichment Vendor/Entertainer Policy," revealed no information related to concerns regarding improving a resident's quality of life by getting her out of bed. No further information was provided prior to exit.	F 675		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		9/10/21

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F 689	Continued From page 71 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement interventions to prevent a resident's injury from a fall for one of 37 residents in the survey staff, Resident #29. The facility staff failed to place Resident #29's call bell within reach and to place fall mats beside the resident's bed on 8/3/21 and 8/4/21. The findings include: Resident #29 was admitted to the facility on 6/21/21 with diagnoses including dementia (1) and bipolar disorder (2). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/22/21, Resident #29 was coded as being severely cognitively impaired for making daily decisions, having scored five out of 15 on the BIMS (brief interview for mental status). She was coded as having had a fall in the month prior to admission, and as having had no falls since admission to the facility. Observations conducted on the following dates and time: 8/3/21 at 12:47 p.m. and 4:00 p.m.; 8/4/21 at 9:53 a.m., revealed Resident #29 was observed lying in bed. During each observation, Resident #29's call bell was lying on the floor behind the head of her bed and there were no fall mats on the floor beside the resident's bed. A review of Resident #29's clinical record revealed she had sustained falls without injury on 7/1/21, 7/2/21, and 7/21/21.	F 689	Corrective Action(s): Resident #29 now has her call bell placed within reach and a fall mat has been placed beside her bed while she is in bed. Her Care plan has been reviewed and revised to reflect her current care needs. Identification of Deficient Practice(s) & Corrective Action(s): Current residents with physician ordered fall prevention interventions may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of current residents with physician ordered fall prevention interventions to identify residents at risk for inconsistent implementation of the intervention/equipment. Any residents identified at risk will be corrected at time of discovery and their comprehensive care plans updated to reflect their current fall prevention interventions. Systemic Change(s): The facility policy and procedure for fall prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or ADON will inservice all nursing staff, to include agency staff and new hires on the proper use of and application of fall prevention interventions/equipment to include fall mats, call bells, concave mattresses to prevent falls and/or reduce potential injury.	

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F 689	Continued From page 72 A review of Resident #29's comprehensive care plan, dated 6/22/21 and updated 7/22/21, revealed, in part: "Minimize risks for falls/minimize injuries related to falls: "Fall mat to right side of bed...Implement preventative fall interventions/devices...Maintain call light within reach. Educate resident to use call light." On 8/4/21 at 12:53 p.m., LPN (licensed practical nurse) # 2 was interviewed. When asked where call bells should be placed in resident rooms, she stated the call bells should always be within a resident's reach. When asked who is responsible for making sure the call bells are in reach, LPN #2 stated, "It is everybody's responsibility. Everyone who enters the room." When asked how staff members know which interventions should be implemented to prevent injury from a fall, she stated the information and interventions are passed on in report and are always on the care plan. LPN #2 stated she makes sure CNAs (certified nursing assistants) working on her shift know if any residents have specific fall prevention measures to be implemented. On 8/4/21 at 3:44 p.m., RN (registered nurse) #3 was interviewed. When asked how makes certain fall prevention interventions are implemented, she stated it is all staff's responsibility. She stated fall prevention measures are usually listed on the care plan. RN #3 stated any updates or changes to the care plan are passed along in report, and she passes this information along to CNAs and other staff who are caring for a resident. She stated fall prevention measures help lessen the chance for a resident sustaining injury. On 8/4/21 at 4:54 p.m., ASM (administrative staff	F 689	Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform 3 audits weekly for 12 weeks of all residents with physician order fall interventions/equipment to monitor for compliance. Any negative findings will be corrected at time of discovery. Audits findings will reported to QAPI monthly for 3 months for review and recommendations for 3 months.	

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member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

On 8/5/21 at 8:43 a.m., CNA #5 was interviewed. When asked where a resident's call bell should be located, she stated it should be located within a resident's reach. When asked if she is aware of any fall prevention interventions in place for Resident #29, she stated she would have to check with the nurse. When asked who is responsible for making sure fall prevention interventions are in place for residents, CNA #5 stated, "I am. And I guess all of us."

A review of the facility policy, "Fall Prevention and Management Policy," revealed, in part: "Falls will be reviewed by an interdisciplinary team and any new interventions identified will be implemented and the care plan updated as necessary. Such review should include results of the new fall risk assessment, discussion with resident and/or any witnessing parties as to potential causal factors, review of the environment where the fall occurred, and discussion as to any new interventions which may help to prevent further falls."

No further information was provided prior to exit.

REFERENCES
(1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.

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F 689	Continued From page 74 (2) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: The facility staff failed to provide respiratory care, consistent with professional standards of practice, and the comprehensive person-centered plan of care for one of 37 residents in the survey sample, Resident #17. The facility staff failed to replace Resident #17's nebulizer tubing (1) as ordered by the physician. The findings include: Resident #17 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (COPD) (2) and atrial fibrillation (3).	F 695	Corrective Action(s) Resident #17's nebulizer mask, tubing and storage bag were discarded and replaced with a new nebulizer, tubing and storage bag. Identification of Deficient Practice & Corrective Action(s): All current residents receiving physician ordered nebulizer treatments may have potentially been affected. A 100% review of current residents with physician ordered nebulizer treatments will be conducted to identify any/all residents at risk. Any negative findings were corrected at time	9/10/21

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F 695	Continued From page 75 Resident #17's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/8/2021, coded Resident #17 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Section G coded Resident #6 as requiring extensive assistance from two staff members for bed mobility, transfers and toilet use. On 8/3/2021 at approximately 1:20 p.m., an observation was made of Resident #17 in bed in her room. A nebulizer machine was observed on Resident #17's nightstand beside the bed. A mask nebulizer delivery device with tubing was observed plugged into the machine. The mask delivery device was observed in a plastic bag labeled with Resident #17's name, room number and dated 6/16/21. The tubing of the nebulizer deliver device contained a label with the date 6/16/21 on it. At this time, an interview was attempted with Resident #17. Resident #17 did not answer appropriately when asked about the nebulizer. Additional observations of Resident #17's room on 8/3/2021 at 4:05 p.m. and 8/4/2021 at 8:30 a.m. revealed the nebulizer mask delivery device in the bag dated 6/16/21 and the mask nebulizer delivery device dated 6/16/21. The physician orders for Resident #17 documented in part, - "Neb (nebulizer) tubing changed every Wednesday and prn (as needed). Order Dated 6/3/2021..." - "Albuterol Sulfate Nebulization Solution 2.5 MG (milligram)/0.5 ML (milliliter) 3 ml inhale orally via	F 695	of discovery. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All Nursing staff, to include agency staff and new hires will be inserviced by the DON and/or ADON on the proper procedure for storing and changing nebulizer masks, tubing and storage bags weekly and PRN. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform 3 audits weekly on residents with Nebulizer treatments for 12 weeks to monitor for compliance. Any negative findings will be corrected at time of discovery. Audit findings will be reported to the QAPI Committee for review and recommendations monthly for 3 months.	

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F 695	Continued From page 76	F 695		

(by way of) nebulizer every 6 (six) hours as needed for COPD. Order Date: 06/02/2021..."
- "Brovana Nebulization Solution 15 MCG (micrograms)/2 ML, 2 ML inhale orally via nebulizer two times a day for COPD rinse mouth with water after each use. Order Date: 06/03/2021..."

The eMAR (electronic medication administration record) for Resident #17 dated 6/1/2021-6/30/2021 documented Resident #17 receiving the Brovana Nebulization Solution on 6/3/2021 through 6/8/2021, 6/12/2021 through 6/13/202021, 6/15/2021 through 6/16/2021 at 5:00 p.m., and 6/19/2021 through 6/30/2021.

The eMAR for Resident #17 dated 7/1/2021-7/31/2021 documented Resident #17 receiving the Brovana Nebulization Solution each day except for 7/22/2021 and 7/26/2021.

The eMAR for Resident #17 dated 8/1/2021-8/31/2021 documented Resident #17 receiving the Brovana Nebulization Solution on 8/1/2021 and 8/2/2021.

The comprehensive care plan for Resident #17 dated 6/3/2021 documented in part, "Resident has COPD-potential for impaired airway. Date Initiated: 06/03/2021..."

On 8/4/2021 at approximately 12:44 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that nebulizer tubing and sets were changed every week on Tuesday night. LPN #2 stated that nebulizers were stored in a plastic bag with the resident's name, room number and the date on them. LPN #2 stated that the nebulizer tubing set was also

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dated. LPN #2 stated that the nebulizers were changed to keep them clean.

On 8/4/2021 at approximately 1:30 p.m., an interview was conducted with LPN #3. LPN #3 stated that nebulizer's were changed weekly and as needed when soiled. LPN #3 stated that the nebulizer was stored in a bag when not in use with the resident's name, room number and the date on them. LPN #3 stated that the purpose of changing the nebulizer weekly was for infection control purposes.

On 8/4/2021 at approximately 1:35 p.m., LPN #3 observed the nebulizer mask delivery device in Resident #17's room dated 6/16/21 and stated that they could not say why the date was back in June because it should have been changed on 8/3/2021.

On 8/3/2021 at approximately 2:30 p.m., ASM (administrative staff member) #1, provided a title page from the Lippincott Manual of Nursing Practice, Eleventh Edition via email as their nursing standard of practice requested during entrance.

According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer, tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the

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F 695	Continued From page 78 lungs." On 8/5/2021 at approximately 11:00 a.m., a request was made to ASM #1 for the facility policy for the use of nebulizers. The facility policy "Nebulizer Administration Policy" dated 12/16/2019 failed to evidence guidance on frequency of replacing the nebulizer mask delivery device. On 8/4/2021 at approximately 4:55 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations and ASM #4, the regional nurse consultant were notified of the findings. No further information was provided prior to exit. References: 1. Nebulizer: "A device used to aerosolize medications for delivery to patients." Taken from Encyclopedia & Dictionary of Medicine, Nursing & Allied Health -Seventh Edition, Miller-Keane, page 1182. 2. Chronic obstructive pulmonary disease (COPD): Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 3. Atrial fibrillation: A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: <https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html>.	F 695		
F 700 SS=D	Bedrails	F 700		9/10/21

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F 700	Continued From page 79 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for two of 37 residents in the survey sample, (Residents #31 and #67). 1. The facility staff implemented bed rails for Resident #31 without a documented clinical need and failed to obtain informed consent for the use of bed rails. 2. The facility staff failed to evidence Resident	F 700	Corrective Action(s): Residents #31, & #67 have been reassessed by nursing for the use of quarter rails for mobility and repositioning. The resident's comprehensive care plans have been revised to reflect their current use of quarter rails while in bed for mobility and repositioning. Identification of Deficient Practice(s) & Corrective Action(s): All current residents using quarter rails for turning and positioning while in bed may	

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F 700	Continued From page 80 #67 was assessed for risk of entrapment, failed to review risks / benefits and failed to obtain informed consent prior to the use of bed rails. The findings include: 1. Resident #31 was admitted to the facility on 1/3/20. Resident #31's diagnoses included but were not limited to stroke, chronic kidney disease and anxiety disorder. Resident #31's quarterly minimum data set assessment with an assessment reference date of 6/23/21, coded the resident's cognition as severely impaired. Review of Resident #31's clinical record revealed a bed rail assessment dated 5/17/21 that documented, "Medical need(s) for the side rail (bed rail) being considered: Resident hasn't shown any clinical need for side rails at this time. Informed consent obtained from resident/resident representative: NA..." Review of Resident #31's comprehensive care plan initiated on 1/6/20 failed to reveal documentation regarding the use of bed rails. On 8/3/21 at 11:22 a.m. and 8/4/21 at 8:01 a.m., Resident #31 was observed in bed with bilateral U bar bed rails up. On 8/5/21 at 8:35 a.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated some residents use bed rails for turning and repositioning but an assessment must be done to determine the need for bed rails and to determine if bed rails are safe. LPN #5 stated consent for the use of bed rails also has to be obtained. LPN #5 stated that if an assessment determines no need for bed rails	F 700	have potentially been affected. Nursing will conduct a 100% audit of all current residents who use quarter rails to ensure they have been properly assessed for the use of quarter rails, consent has been obtained and that they are being used appropriately to meet the resident's current safety and mobility needs. Any/all negative finding will be corrected at the time of discovery and the residents comprehensive care plans will be revised as needed to reflect their current level of care. Systemic Change(s): Facility policy & procedure has been reviewed and no revisions are warranted at this time. The DON and/or ADON will inservice all licensed nursing staff, to include agency staff and new hires on the procedure for obtaining informed consent and completing the side rail screening/assessment tool prior to initiating side rail use for any residents. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will audit new admission Side rail assessments weekly times 12 weeks coinciding with to monitor for compliance. Audit findings will be reported to the QAPI committee for review and recommendations monthly x 3 months.	

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then the resident should not have them. LPN #5 reviewed Resident #31's bed rail assessment dated 5/17/21. LPN #5 stated that the assessment documented no need for bed rails and no consent. LPN #5 stated she thought Resident #31 currently did need bed rails.

On 8/5/21 at 9:36 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility bed rail policy documented, "1. The facility will attempt to use appropriate alternatives prior to installing a side or bed rail.
2. If a bed or side rail is used, the facility will:
a. Assess the potential risks associated with the use of bed rails including the risk of entrapment, prior to bed rail installation.
b. Assess the risk versus benefits of using a bed rail and review them with the resident or if applicable, the resident's representative.
c. Obtain informed consent for the installation and use of bed rails prior to the installation..."

No further information was presented prior to exit.

2. The facility staff failed to evidence Resident #67 was assessed for risk of entrapment, failed to review risks / benefits and failed to obtain informed consent prior to the use of bed rails.

Resident #67 was admitted to the facility on 12/29/20. Resident #67's diagnoses included but were not limited to: Alzheimer's disease (progressive loss of mental ability and function often accompanied by personality changes) (1), fracture of left femur (break in left thighbone) (2) and degeneration of discs (physical decline that

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involves tissue and cellular changes of the cushioning tissue between the vertebrae) (3).

Resident #67's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/25/21, coded the resident as scoring 99 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was unable to complete the interview. MDS Section G- Functional Status: coded the resident, as extensive assistance with bed mobility, transfers, dressing, eating, personal hygiene and bathing; walking and locomotion did not occur. A review of MDS Section H- Bowel and Bladder: coded the resident as always incontinent for bowel and for bladder.

Resident #67 was observed in bed with bilateral side rails up on 8/3/21 at 11:30 AM and 8/4/21 at 8:05 AM.

A review of the physician orders documented "Bilateral side bars for assist."

A review of Resident #67's medical record, failed to evidence, assessment for risk of entrapment, failed to review risks / benefits and failed to obtain informed consent.

A review of the bed rail inspection was completed for 2021, with the bed and rails passing.

A review of Resident #67's comprehensive care plan dated 12/21/20 and revised on 6/15/21, documents in part, "FOCUS-The resident has self-care deficit. INTERVENTIONS-Assist with activities of daily living, dressing, grooming, toileting, feeding and oral care. Evaluate needs for adaptive equipment." There was no

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documented evidence of bed rails on the comprehensive care plan when reviewed on 8/3/21 and 8/4/21.

A review of Resident #67's comprehensive care plan on 8/5/21, documented in part, the following revision to the care plan on 8/4/21 "Two assist rails to bed."

A review of Resident #67's medical record, failed to evidence, an assessment for risk of entrapment, failed to evidence a review of the risks / benefits for the use of bed rails with Resident #67 and or the resident s representative, and failed to reveal informed consent was obtained prior to the use of bed rails.

A request was made on 8/5/21 at 9:20 AM for the evidence of assessment for risk of entrapment, risks / benefits and informed consent for the bedrails for Resident #67.

On 8/5/21 at 9:55 AM, ASM (administrative staff member) #1, the administrator, returned and stated, "We do not have any of the documentation you requested for Resident #67."

An interview was conducted on 8/4/21 at 11:01 AM with LPN (Licensed practical nurse) #1. When asked what documentation is needed for bedrails, LPN #1 stated, "You need a risk assessment, discussion of risks and benefits and a consent."

An interview was conducted on 8/4/21 at 3:24 PM with RN (registered nurse) #2. When asked what documentation is needed for bedrails, RN #2 stated, "You need a bed rail assessment which is completed on admission, with risks and benefits."

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F 700	Continued From page 84 When asked if you have to get consent, RN #2 stated, "You're supposed to." On 8/05/21 at 11:30 AM, ASM #1, the administrator, ASM #2, the director of nursing and ASM, the regional VP of operations were informed of the concern. A review of the facility's "Bed Rails" policy dated 4/2/18, documents in part, "If a bed or side rail is used, the facility will: assess the potential risks associated with the use of bed rails including the risk of entrapment, prior to bed rail installation. Assess the risk versus benefits of using a bed rail and review them with the resident. Obtain informed consent for the use of the bed rails prior to installation." No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 25. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 218/232. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 153.	F 700		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		9/10/21

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F 757	Continued From page 85 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interviews, clinical record reviews and facility document reviews it was determined that the facility staff failed to ensure one of 37 residents in the survey sample was free of unnecessary medications, Resident #58. The facility staff failed to implement non-pharmacological interventions prior to the administration of as needed pain medication for Resident #58. The findings include: Resident #58 was admitted to the facility with diagnoses that included but were not limited to encephalopathy (1) and cirrhosis of the liver (2). Resident #58's most recent MDS (minimum data set), an admission assessment with an ARD	F 757	Corrective Action(s): Resident #58's attending physician has reviewed resident #58's medication regime and the PRN pain medication has been changed to scheduled delivery three times a day. Identification of Deficient Practice(s) & Corrective Action(s): All current residents receiving PRN pain medication may have potentially been affected. The DON, ADON, and/or Unit Manager will review the medication orders of current residents receiving PRN pain medication to ensure that non-pharmacological interventions are ordered and attempted prior to administering PRN pain medications. Any/all negative findings will be communicated to the attending physicians	

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F 757	Continued From page 86 (assessment reference date) of 7/18/2021, coded Resident #58 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Section J coded Resident #58 as receiving scheduled and as needed pain medications. Section J further coded Resident #58 as not receiving non-medication interventions for pain and having pain almost constantly. On 8/3/2021 at approximately 4:15 p.m., an interview was conducted of Resident #58 in their room. When asked about pain management, Resident #58 stated that pain medications had to be requested to the nurses when needed. Resident #58 stated that the nurses assessed his pain by asking him what number his pain was and provided the medication. When asked if staff attempted non-pharmacological interventions to relieve his pain prior to administering the medication, Resident #58 stated that they just gave him the medication. The physician orders for Resident #58 documented in part, - "oxyCODONE HCL [hydrochloride] Tablet 5 MG, Give 2 (two) tablet by mouth every 4 (four) hours as needed for pain. Order Date: 07/13/2021. End Date: 07/16/2021." - "Dilaudid Tablet 2 MG (milligram) (HYDROmorphone HCL) Give 1 (one) tablet by mouth every 4 (four) hours as needed for pain. Order Date: 07/16/2021." The eMAR (electronic medication administration record) dated 7/1/2021-7/31/2021 documented the Oxycodone was administered to Resident #58 on: 7/13/2021 at 4:08 p.m. for a pain level of seven, on 7/14/2021 at 4:02 p.m. for a pain level	F 757	for corrective action. Systemic Changes: All nursing staff, to include agency staff and new hires will inserviced by the DON and/or ADON on the facility policy and procedure for administration and monitoring of all medications. This includes attempting non-pharmacological interventions prior to administration of PRN pain medications. Monitoring: The DON, ADON and/or Unit Manager will complete weekly MAR audits coinciding with the care plan calendar to monitor compliance weekly for 12 weeks. All negative findings will be reported to the attending physician for correction. Audit findings will be reported to the QAPI committee for review, analysis, and recommendations for change in facility policy, procedure and practice.	

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of seven and on 7/16/2021 at 1:39 a.m. for a pain level of seven.

The eMAR dated 7/1/2021-7/31/2021 documented the Dilaudid was administered to Resident #58 on 7/17/2021 at 6:20 a.m. for a pain level of five and at 12:13 p.m. for a pain level of five. The eMAR further documented Resident #58 receiving the Dilaudid on 7/18/2021 at 12:10 p.m. for a pain level of eight, on 7/20/21 at 8:38 p.m. for a pain level of eight, on 7/22/21 at 1:23 a.m. for a pain level of eight and on 7/26/21 at 9:52 a.m. for a pain level of five.

The eMAR dated 7/1/2021-7/31/2021 failed to evidence documentation of non-pharmacological interventions attempted or offered to Resident #58 prior to the administration of the as needed pain medication on the dates and times listed above.

The progress notes for Resident #58 failed to evidence documentation of non-pharmacological interventions attempted or offered to Resident #58 prior to the administration of the as needed pain medication on the dates and times listed above.

The comprehensive care plan for Resident #58 dated 7/13/2021 documented in part, "Resident has reported episodes of pain with potential for further pain. Date Initiated: 07/13/2021. Revision Date: 07/27/2021..." Under "Interventions/Tasks" it documented in part, "...Implement non pharmacological interventions to release the pain like Distraction techniques, relaxation and breathing exercises, music therapy, re-position. Date Initiated: 07/13/2021; Revision on : 07/27/2021..."

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On 8/5/2021 at approximately 8:35 a.m., an interview was conducted with LPN (licensed practical nurse) #5, unit manager. LPN #5 stated that when a resident complained of pain they assessed the resident to determine the level of pain and the possible cause of the pain. LPN #5 stated that interventions other than medication were attempted first to see if they could relieve the pain. LPN #5 stated that a resident's pain may be relieved by repositioning them and they would not require the pain medication. LPN #5 stated that if the non-pharmacological interventions were not successful in relieving the pain, then they would administer the ordered pain medication. LPN #5 stated that this was to minimize the amount of medications administered to the resident unless needed. LPN #5 stated that they utilized non-pharmacological interventions such as relaxation techniques, turning and repositioning to attempt to relieve pain. LPN #5 stated that non-pharmacological interventions were documented on the eMAR (electronic medication administration record) or in the nurse's notes. LPN #5 reviewed the eMAR for Resident #58 dated 7/1/2021-7/31/2021 and progress notes and stated that they did not see documentation that non-pharmacological interventions were attempted prior to the administration of the as needed pain medications documented above.

On 8/5/2021 at approximately 9:20 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that staff were expected to implement non-pharmacological interventions like turning and repositioning or offering a cold pack prior to administering as needed pain medications. ASM

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#2 stated that staff were expected to document the non-pharmacological interventions with their effectiveness in the nurse's notes. ASM #2 was asked to provide evidence of staff offering/implementing non-pharmacological interventions prior to the administration of the as needed pain medications as listed above.

On 8/5/2021 at approximately 10:10 a.m., ASM #2 stated that there were no non-pharmacological interventions documented for Resident #58 on the dates/times listed above.

On 8/5/2021 at approximately 11:00 a.m., a request was made to ASM #1 for the facility policy on pain management.

The facility policy "Pain Management and Pain Protocol" dated 5/21/2015 documented in part, "... Non-pharmacological intervention will be attempted prior to the administration of PRN (as needed) pain medications..."

On 8/5/2021 at approximately 11:30 a.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #3 the regional vice president of operations were made aware of the concern. No further information was provided prior to exit.

References:

1. "Encephalopathy is a general term describing a disease that affects the function or structure of your brain." This information is taken from the website https://www.healthline.com/health/hepatic-encephalopathy.

2. "Cirrhosis is scarring of the liver. Scar tissue

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F 757	Continued From page 90 forms because of injury or long-term disease. Scar tissue cannot do what healthy liver tissue does - make protein, help fight infections, clean the blood, help digest food and store energy." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=cirrhosis&_ga=2.73159383.513196122.1626311381-1838772440.1562936034	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758		9/10/21

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F 758	Continued From page 91 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure a resident did not receive an unnecessary psychotropic medication for one of 37 residents in the survey sample, Resident #59. The facility staff failed to document adequate indications for the use of the anti-anxiety medication Alprazolam, failed to offer non-pharmacological interventions prior to the administration of the medication to Resident #59 and failed to monitor Resident #59 for side effects of the Alprazolam(1). The findings include:	F 758	Corrective Action(s): Resident #59's Alprazolam order has been reviewed and updated to include attempting nonpharmacological interventions prior to administrator of PRN psychotropic medication. Identification of Deficient Practice(s) & Corrective Action(s): All other residents receiving PRN psychotropic medications may have been potentially affected. The DON, ADON and/or pharmacy consultant will audit all current residents with PRN psychotropic medication orders to identify residents without nonpharmacological interventions	

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F 758	Continued From page 92 Resident #59 was admitted to the facility on 7/13/21 with diagnoses including history of a heart attack and heart failure. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/19/21, Resident #59 was coded as being moderately impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status). She was coded as not having received medications to treat anxiety during the look back period. On the following dates and times, Resident #59 was observed lying in bed with her eyes closed: 8/3/21 at 12:22 p.m. and 3:48 p.m.; 8/4/21 at 9:48 a.m. and 4:05 p.m. A review of Resident #59's clinical record revealed the following order, dated 7/26/21: "Alprazolam Tablet 0.25 MG (milligrams) Give 1 tablet by mouth at bedtime for Anxiety." The order was signed by ASM (administrative staff member) #5, the NP (nurse practitioner). A review of Resident #59's diagnosis list failed to reveal evidence of an anxiety diagnosis. A review of Resident #59's July 2021 and August 2021 MARs (medication administration records) revealed she received the Alprazolam as ordered each day. The MARs contained no evidence of monitoring for side effects of the Alprazolam once the resident began receiving it. Further review of Resident #59's clinical record failed to reveal evidence in the progress notes or behavior monitoring records that facility staff had observed Resident #59 to exhibit signs or	F 758	in place. Any/all negative findings will be communicated to the attending physicians for corrective action. Systemic Changes: The facility policy and procedure has been reviewed. No revisions are warranted at this time. All nursing staff, to include agency staff and new hires will be inserviced by the DON and/or ADON on the facility policy and procedure for attempting nonpharmacological interventions prior to administration of PRN psychotropic medication administration. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will complete weekly physician order audits coinciding with the care plan for 12 weeks on all current residents receiving PRN psychotropic medications to monitor for compliance. All negative findings will be corrected at time of discovery. Audit findings will be reported to QAPI committee monthly for 3 months for review, analysis, and recommendations for change in facility policy, procedure and/or practice.	

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symptoms requiring an anxiolytic. A review of ASM #5's progress notes revealed the following note, dated 7/26/21: "Patient seen and examined in room today - remains weak looking and responding poorly in therapy...Daughter c/o (complains of) patient being more anxious at bedtime." The review of the progress notes failed to review evidence that the staff had attempted any other interventions to address Resident #59's reported anxiety prior to initiating the Alprazolam.

A review of Resident #59's baseline care plan dated 7/14/21 did not contain information related to Resident #59's Alprazolam administration. The comprehensive care plan was not due until 8/3/21.

On 8/4/21 at 12:53 p.m., LPN (licensed practical nurse) #2 was interviewed. When asked what she would do for a resident who was exhibiting new signs of anxiety, she stated she would attempt to redirect the resident, and to try to make the resident more comfortable. She stated the sometimes she will place a phone call to family to let the resident hear the family member's voice. When asked if she would request an anxiolytic for the resident, LPN #2 stated, "Only if they already have a known diagnosis of anxiety or agitation - not just because they are confused."

On 8/4/21 at 3:44 p.m., RN (registered nurse) #3 was interviewed and asked about Resident #59's Alprazolam. RN #3 stated she assumes the resident gets it for anxiety. She stated the resident is asleep much of the day and night, but always arouses easily. RN #3 stated the resident does try to crawl out of bed sometimes. When asked what side effects might be present in a resident who receives Alprazolam, RN #3 stated,

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"Mostly too sleepy." RN #3 was asked to review Resident #59's record for evidence that she is being monitored for side effects of receiving Alprazolam. After reviewing Resident #59's clinical record, RN #3 stated, "No. Not that I can see."

On 8/4/21 at 4:54 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (director of nursing), ASM #3, the regional vice-president of operations, and ASM #4, the regional nurse consultant, were informed of these concerns.

On 8/5/21 at 8:19 a.m., ASM #2 was interviewed. She stated ASM #5 could provide more information regarding the indications and reason for starting the resident on Alprazolam. ASM #2 stated she could not find evidence that the resident was being monitored for side effects of Alprazolam prior to the time of survey entrance. She stated the staff usually begins side effect monitoring immediately when a resident starts on a new anxiolytic. ASM #2 stated it is important to monitor for side effects because "[Alprazolam] is contraindicated in the elderly."

On 8/5/21 at 11:21 a.m., ASM #5 was interviewed. She stated Resident #59's daughters told her the resident had taken Alprazolam at home before her hospital admission. ASM #5 stated the daughter had reported the symptoms of anxiety at bedtime, and that is why she started Alprazolam for the resident. She stated the primary side effect is sedation.

A review of the facility policy, "Psychoactive Medication Policy," revealed, in part: "Residents receiving psychoactive medication will have a

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Behavior/Intervention Flow Record (BFR)
Initiated on admission or whenever psychoactive meds [medication] are ordered using the batch order process in the electronic record (other/behavior flow, both interventions and side effects) or paper flow records:
a. Each psychoactive medication will be entered on BFR
b. Resident specific behaviors related to medication use will be entered on BFR
c. Diagnosi[e]s supporting the use of psychoactive medication will be documented in the medical record.

B. Nurses will document on the following each shift:
a. Number of behavior episodes
b. Specific non-medication interventions used - enter code as indicated on BFR
c. Outcome of interventions - use code key listed on BFR
i. Behavior Interventions - individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychological environment and are directed toward preventing, relieving or accommodating a resident's distressed behavior.
d. Any side effect(s) observed-use code key listed on BFR."

No further information was provided prior to exit.

REFERENCES
(1) "Alprazolam is used to treat anxiety disorders and panic disorder (sudden, unexpected attacks of extreme fear and worry about these attacks). Alprazolam is in a class of medications called benzodiazepines. It works by decreasing

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F 758	Continued From page 96 abnormal excitement in the brain." This information was taken from the website https://medlineplus.gov/druginfo/meds/a684001.html.	F 758		
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 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 document review it was determined facility staff failed to store food and failed to to maintain dietary equipment in a sanitary manner. The facility failed to dispose of tomatoes in the walk-in refrigerator with visible black spots and signs of spoilage and observation of the round blade on the kitchens electric food slicer revealed a rust-colored area on the surface and edging of	F 812	Corrective Action(s): The spoiled tomatoes were removed from walk-in refrigerator and disposed of. The electric food slicer was cleaned and sanitized and rust-colored area was removed from blade. Identification of Deficient Practice(s) & Corrective Action(s): A 100% audit of produce was conducted	9/10/21

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F 812	Continued From page 97 the blade approximately one-quarter inch in size. The findings include: 1. On 8/3/2021 at approximately 11:15 a.m., an observation was conducted in the kitchen of the facility with OSM (other staff member) #2, the dietary manager. Observation of the kitchen's walk in refrigerator revealed a 25 pound cardboard box of tomatoes with a date of 7/26/21 hand-written on the lid. Upon removal of the lid from the box, four tomatoes were observed with visible signs of spoilage on them. Two tomatoes were observed with black colored spots on the surface of the outer skin and two tomatoes were observed with a white colored substance at the stem area of the tomato. On 8/3/2021 at approximately 11:30 a.m., an interview was conducted with OSM #2. OSM #2 observed the tomatoes in the walk-in refrigerator and stated that they normally received much smaller boxes of tomatoes and that normally they did not keep so many in the refrigerator. OSM #2 stated that when they pulled produce out to use it, they discarded any produce that had signs of spoilage on it. OSM #2 stated that normally they checked the produce daily but due to staffing only two employees in the kitchen currently they were unable to check them like they used to. OSM #2 stated that they had modified their process to discard any spoiled items when they pulled things out to cook meals. OSM #2 stated that the date 7/26/21 written on the lid of the box was the date that it was received in the facility and that they thought they kept produce for 14 days but had to check their policy to confirm. On 8/4/2021 at approximately 8:10 a.m., a	F 812	to examine produce for signs of spoilage. Any produce with signs of spoilage was removed and disposed of. A 100% audit of kitchen appliances was conducted to identify appliances that required cleaning and repair. Any negative findings were corrected at the time of discovery. Systemic Changes: The Dietary Manager and Dietary staff have been inserviced by the Dietician on the procedure for inspecting produce and perishable foods for signs of spoilage daily and proper storage of produce and perishable foods. Monitoring: The Dietary Manager/Designee will complete a daily audit of produce for signs of spoilage for 12 weeks to monitor for compliance. The Maintenance Director/Designee will complete a weekly audit of kitchen appliances for any needed cleaning, repairs or maintenance for 12 weeks to monitor for compliance. The audit results will be reported to the QAPI committee monthly for 3 months for review and recommendations.	

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request was made to OSM #2 for the facility policy on storage of produce in the walk-in refrigerator.

On 8/4/2021 at approximately 10:05 a.m., OSM #2 provided the policy "Use-by Guide-Quick Reference" and stated that the produce was kept for seven days. OSM #2 stated that the tomatoes were received on 7/26/21. OSM #2 stated that seven days after receipt would be 8/2/2021.

The facility policy "Use-By Guide - Quick Reference" documented in part, "...Note: Storage guidelines above are meant as a general guide- Be alert for food spoilage; anything that looks or smells suspicious should be discarded immediately."

On 8/4/2021 at approximately 4:55 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations and ASM #4, the regional nurse consultant were notified of the findings.

On 8/5/2021 at approximately 8:00 a.m., ASM #1, the administrator provided a typed memo which documented, "Spoiled Produce. 8/4/2021. All produce was checked in the walk in dietary refrigerator. Spoiled tomatoes were disposed of and no other issues were found with the remaining produce. [Signature of ASM #1]."

No further information was provided prior to exit.

2. On 8/3/2021 at approximately 11:15 a.m., an observation was conducted in the kitchen of the facility with OSM (other staff member) #2, the dietary manager. Observation revealed the

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kitchen's electric food slicer covered with a plastic bag. OSM #2 stated that the slicer was clean and ready for use. Observation of the round blade on the slicer revealed a rust-colored area on the surface and edging of the blade approximately one-quarter inch in size.

On 8/3/2021 at approximately 12:15 p.m., OSM #2 was observed slicing turkey for lunch service on the electric food slicer.

On 8/4/2021 at approximately 8:10 a.m., an interview was conducted with OSM #2. OSM #2 observed the blade on the electric food slicer and stated that they saw the rust-colored area on the blade on 8/3/2021 when they took it apart to clean it after use at the lunch service. OSM #2 stated that maintenance would have to come to look at the blade and see if they could remove the area because they were unable to remove it by washing it. OSM #2 stated that the area appeared to be rust. OSM #2 proceeded to call maintenance to report the area on the blade at that time.

On 8/4/2021 at approximately 10:05 a.m., OSM #2 stated that maintenance had removed the rust from the blade on the slicer and they were checking with them to see if they had a policy on maintenance of the slicer.

On 8/5/2021 at approximately 11:00 a.m., a request was made to ASM (administrative staff member) #1 for the facility policy on maintenance and care of the electric food slicer.

On 8/5/2021 at approximately 12:06 p.m., ASM #3, the regional vice president of operations provided the policy "Resource- Cleaning

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Instructions- Food processor/Blender."

The facility policy "Resource- Cleaning Instructions- Food Processor/Blender" documented in part, "It will be cleaned as needed and according to the cleaning schedule...Maintenance: Replace notched or broken blade. Report dull blade to the Maintenance Department."

On 8/4/2021 at approximately 4:55 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional vice president of operations and ASM #4, the regional nurse consultant were notified of the findings.

On 8/5/2021 at approximately 8:00 a.m., ASM #1, the administrator provided a typed memo which documented, "Berkel 827A Meat Slicer. The meat slicer in the kitchen at [Name of Facility] was taken by Maintenance Director to the Maintenance office to clean for possible rust on the blade. The blade is stainless steel and therefore does not rust. The blade was cleaned with a cloth to clean debris off, and polish blade, which came out looking new. Completed on 8/4/2021. Attached is the info (information) on the meat slicer for reference. [Signature of OSM #6, director of maintenance]."

On 8/5/2021 at approximately 9:15 a.m., an interview was conducted with OSM #6, the director of maintenance. OSM #6 stated that they inspected the equipment in the kitchen quarterly and as needed when dietary staff reported any concerns. OSM #6 stated that they had removed the rust-colored debris from the blade on the electric food slicer by using a rough cloth.

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F 812	Continued From page 101 No further information was provided prior to exit.	F 812		