STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495209	A. BUILDING ______ B. WING ______	C 04/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RALEIGH COURT HEALTH AND REHABILITATION CENTER	**1527 GRANDIN ROAD SOUTHWEST ROANOKE, VA 24015**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 03/30/2021 through 04/19/2021. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 96 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1, #2, and #5) and 3 closed record reviews (Residents #3, #4 and #6).	F 000		
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 resident interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigations, the facility staff failed to implement their policy on investigating an allegation of abuse for 1 of 6 residents, Resident #5. The findings included:	F 607	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all	5/14/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/05/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 607

Continued From page 1

The facility staff failed to follow their policy in regards to investigating an allegation of abuse made by a resident of the facility.

The face sheet in Resident #5's (EHR) electronic health record included information to indicate this resident was their own (RP) responsible party.

The clinical record included the diagnosis cognitive communication deficit, history of urinary tract infections, insomnia, depressive disorder, and diabetes.

Section C (cognitive patterns) of Resident #5's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 01/29/2021 included a (BIMS) brief interview for mental status summary score of 15. Per the MDS (RAI) resident assessment instrument manual a score of 13-15=cognitively intact. Section E (behavior) was coded to indicate the resident had not exhibited any behaviors in the look back period. Section G (functional status) was coded to indicate the resident required extensive assistance of one person (3/2) for bed mobility, transfers, dressing, and toilet use. Personal hygiene, walk in room, and walk in corridor was coded (2/2) indicating the resident required limited assistance of one person for these tasks. Bathing was coded (4/2) for total dependence of one staff. The resident was coded as using a wheelchair for mobility.

Resident #5's (CCP) comprehensive care plan included the focus areas has insomnia, uses psychotropic medications related to depression, resistive to care at times, (ADL) activities of daily living self-care performance deficit, bowel and

F 607

federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F607

1. Resident #5 reported an allegation of sexual abuse. The allegation has been investigated.

2. Current residents will be reviewed to determine any allegations and/or instances of abuse. Administrator will be immediately notified. An investigation will begin. A report will be filed as applicable. Any issues will be corrected at the time of identification.

3. Current center staff will be educated regarding alleged/actual abuse identification and reporting requirement. Staff will report any allegation or actual abuse situation immediately to the Administrator and an investigation will begin. Any issues will be corrected at the time of identification.

4. Process will be reviewed in next quarterly QA committee meeting.

5. 5/14/21

6. Amy Taylor, DON

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F 607	Continued From page 2 bladder incontinence, has a communication problem related to hearing deficit, mixed receptive expressive language disorder, and cognitive communication deficit. Interventions included, but were not limited to, observe resident for delusional thoughts, give clear explanation of all care activities prior to and as they occur during each contact, incontinence care as needed, clean peri-area with each incontinence episode, monitor/document for signs/symptoms of urinary tract infection, monitor/document/report as needed any signs/symptoms of behavioral changes, nervousness, increased irritability, emotional lability, insomnia, extreme fatigue, confusion, disorientation, delirium psychosis, stupor, and coma. The facility policy titled "Reporting Requirements/Investigations" from manual section "Abuse/Neglect/Misappropriation/Crime" with an effective date of 01/23/20 read in part, "The Administrator will ensure the timely reporting, investigating, and follow up reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a patient to the State Agency and any other appropriate authorities...Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment...the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. Notify the Virginia Department of Health Office of	F 607		

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F 607	Continued From page 3 Licensure and Certification by filing the initial report on the Virginia Department of Health Facility Reported Incident Form...Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities...for any incident of patient abuse, mistreatment, neglect...or other reasonable suspicion of a crime...The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individual, agents, or authorities to assist in the process and determinations...The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted (FRI) facility reported incident to the Virginia Department of Health Office of Licensure and Certification within five (5) working days of the incident...The written follow-up investigative reporting document that is submitted must contain sufficient detail to demonstrate a thorough investigation was conducted, It must include, but is not limited to: a. Date of the occurrence. b. Name of the patient, staff, or individuals involved. c. Location of and description of the injury to the patient. d. Location and description of the occurrence. e. Immediate action taken to protect the patient from further injury. f. Mechanisms in place to prevent recurrence of the incident, including date of review of Center policies and procedures. g. Documentation of reports to Adult Protective	F 607		

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Services, law enforcement, or the Department of Health Professions, as appropriate..."

12/01/2020, Resident #5 was seen by the (PA) physician assistant for "... (c/o) complaints off burning upon urination. Nursing reports that she seems more confused today as well...Urinary tract infection with hematuria...urinalysis obtained earlier today, positive for (UTI) urinary tract infection-start Cipro 250mg..."

12/04/2020 8:07 a.m. (LPN) licensed practical nurse #4 documented "...was very confused and aggressive this AM. She accused staff of raping her and she also, scratched the (NA) nurse aide trying to help her to get on her chair as per her request."

The facility provided the surveyor with a copy of a handwritten document dated "12/4/2020" that had been signed by the (DON) director of nursing. Conversation held with (Resident #5) on 12/4/2020. Met with patient to discuss events from night before "staff raped me." Asked pt if she felt safe here in facility: Pt states she had been assaulted; when asked by who rsd states "I don't know his name, he's the night watchman." "His sister is my roommate and she is very powerful." Unable to give date of occurrence. Asked rsd to describe the man. Tall, large, crew cut, blonde. He told me he raped me those are his words not mine. I was asleep. (Resident #5) was confused and aggressive this morning. Currently, being treated for UTI recently started on Lexapro. Attempted to assess pt, she refuses. No employee matching this description employed. Roommate does not have family employed here.

04/01/2021, Resident #5 attended an out of

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facility appointment accompanied by a family member. While on this appointment Resident #5 stated to the staff that she had been abused by one of the male nursing home workers.

04/12/2021 11:58 a.m., the surveyor spoke with Resident #5 in their room. Resident #5 was alert and orientated to self. When asked if they had been abused by anyone Resident #5 stated I do not want to tell it all over again. Resident #5 did state it was one of the staff, a big male person, and it happened in the middle of the night. Resident #5 stated the person was white, they did not have a mask in place, and they did work at the facility. When asked if they had saw this person lately Resident #5 stated yes, I don't want to and stated she did not know the persons name. Resident #5 stated they told the head nurse and they fired the person.

04/12/2021 12:10 p.m., (CNA) certified nursing assistant #7 stated the resident was requiring more help due to becoming incontinent and that was a change for her. It was explained to her but I do not think she understood, she was complaining of being raped, and did not like a male person cleaning her. CNA #7 stated she reported the allegation to the nurse (no longer employed at the facility), the resident was not quiet about it, and they now had a female to work with the patient.

04/12/2021 12:20 p.m., the DON stated an FRI was not completed in December 2020, as the employee description did not match anyone working at the facility.

The surveyor requested a list of all caucasian male employees currently employed at the facility.

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F 607	Continued From page 6 All of these employees were interviewed. LPN #4 stated that one time the resident was rolling around the hallway talking to herself and they seemed to recall the resident accused ______ (first name only given) said she was being raped. Maybe when she was being changed she did not want to be changed. LPN #4 stated he mentioned this to a couple other employees and it was in the fall. LPN #4 stated it was absolutely false when I am there it is on my watch and I am a pain in the a**. I have a strict protocol if there was something going on I would know all the CNA's are great. Other staff #10 was asked if they were aware of any accusations the resident made. This staff stated the resident had not said anything to them directly but they had heard some of the nursing staff say she had said things when she was confused. 04/12/2021 3:10 p.m., other staff #6 obtained permission to speak with the surveyor from Resident #5. After receiving permission other staff #6 stated Resident #5 was at the office on 04/01/2021 and was asked a list of questions to include did she feel safe at home to which Resident #5 answered, no and stated a male employee abused her at _______ nursing home and he had since been fired. Other #6 stated the provider reached out to her and Resident #5 answered the questions the same way when she asked them. Other #6 stated the resident did not want to talk about the incident and got upset and stated it was over and done with. (APS) adult protective services was called. Other #6 stated there were no specifics about the male employee or the allegation. However, Resident #5 had told the provider they had fought back to include scratching and punching the male employee.	F 607		

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04/12/2021 3:35 p.m., during a meeting with the administrator, DON, regional nurse consultant, and (ADON) assistant director of nursing. These staff were asked why an FRI was not completed. The administrator stated the DON spoke with Resident #5 and the Resident stated it was night watchman, they had no staff that matched that description, based on their observation, and the resident having a UTI no FRI was completed.

04/12/2021 4:00 p.m., these same staff stated the resident was their own RP so the family was not notified and the staff person with the same first name as LPN #4 referred to was a short person with brown/black hair.

04/13/2021 9:30 a.m., APS #1 stated the facility had not reported this incident.

04/13/2021 9:53 a.m., the administrator and DON were asked other than speaking with the resident was any other investigation completed. The administrator replied, no, I do not think so based on what the resident told us.

The administrator stated they had no male caucasian staff that were terminated in October, November, or December of 2020 and they did not have a night watchman.

No further information regarding this issue was provided to the survey team prior to the exit conference.

This is a complaint deficiency.

F 609 Reporting of Alleged Violations F 609 5/14/21
SS=D CFR(s): 483.12(c)(1)(4)

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§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 by:
Based on resident interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigations, the facility staff failed to report an allegation of abuse for 1 of 6 residents, Resident #5.

The findings included:

F 609

F609
1. Resident #5 reported an allegation of sexual abuse. The allegation has been investigated.

2. Current residents will be reviewed to determine any allegations and/or instances of abuse. Administrator will be

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F 609	Continued From page 9 The facility staff failed to report an allegation of abuse made by a resident of the facility to the appropriate state agencies. The face sheet in Resident #5's (EHR) electronic health record included information to indicate this resident was their own (RP) responsible party. The clinical record included the diagnosis cognitive communication deficit, history of urinary tract infections, insomnia, depressive disorder, and diabetes. Section C (cognitive patterns) of Resident #5's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 01/29/2021 included a (BIMS) brief interview for mental status summary score of 15. Per the MDS (RAI) resident assessment instrument manual a score of 13-15=cognitively intact. Section E (behavior) was coded to indicate the resident had not exhibited any behaviors in the look back period. Section G (functional status) was coded to indicate the resident required extensive assistance of one person (3/2) for bed mobility, transfers, dressing, and toilet use. Personal hygiene, walk in room, and walk in corridor was coded (2/2) indicating the resident required limited assistance of one person for these tasks. Bathing was coded (4/2) for total dependence of one staff. The resident was coded as using a wheelchair for mobility. Resident #5's (CCP) comprehensive care plan included the focus areas has insomnia, uses psychotropic medications related to depression, resistive to care at times, (ADL) activities of daily living self-care performance deficit, bowel and bladder incontinence, has a communication	F 609	immediately notified. An investigation will begin. A report will be filed as applicable. Any issues will be corrected at the time of identification. 3. Current center staff will be educated regarding alleged/actual abuse identification and reporting requirement. Staff will report any allegation or actual abuse situation immediately to the Administrator and an investigation will begin. Alleged abuse will be reported to the appropriate state agencies. Any issues will be corrected at the time of identification. 4. Process will be reviewed in next quarterly QA committee meeting. 5. 5/14/21 6. Amy Taylor, DON	

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F 609	Continued From page 10 problem related to hearing deficit, mixed receptive expressive language disorder, and cognitive communication deficit. Interventions included, but were not limited to, observe resident for delusional thoughts, give clear explanation of all care activities prior to and as they occur during each contact, incontinence care as needed, clean peri-area with each incontinence episode, monitor/document for signs/symptoms of urinary tract infection, monitor/document/report as needed any signs/symptoms of behavioral changes, nervousness, increased irritability, emotional lability, insomnia, extreme fatigue, confusion, disorientation, delirium psychosis, stupor, and coma. The facility policy titled "Reporting Requirements/Investigations" from manual section "Abuse/Neglect/Misappropriation/Crime" with an effective date of 01/23/20 read in part, "The Administrator will ensure the timely reporting, investigating, and follow up reporting of incidents of alleged/suspected patient abuse, neglect, mistreatment, exploitation, or crime against a patient to the State Agency and any other appropriate authorities...Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment...the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. Notify the Virginia Department of Health Office of Licensure and Certification by filing the initial	F 609		

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F 609	Continued From page 11 report on the Virginia Department of Health Facility Reported Incident Form...Notify the Adult Protective Services Agency, the local Ombudsman, and the appropriate local law enforcement authorities...for any incident of patient abuse, mistreatment, neglect...or other reasonable suspicion of a crime...The Administrator and/or Director of Nursing will immediately initiate a thorough internal investigation of the alleged/suspected occurrence. The investigative protocol will include, but not be limited to, collecting evidence, interviewing alleged victims and witnesses, and involving other appropriate individual, agents, or authorities to assist in the process and determinations...The Administrator must thoroughly investigate and file a complete written report of the investigation of the submitted (FRI) facility reported incident to the Virginia Department of Health Office of Licensure and Certification within five (5) working days of the incident...The written follow-up investigative reporting document that is submitted must contain sufficient detail to demonstrate a thorough investigation was conducted, It must include, but is not limited to: a. Date of the occurrence. b. Name of the patient, staff, or individuals involved. c. Location of and description of the injury to the patient. d. Location and description of the occurrence. e. Immediate action taken to protect the patient from further injury. f. Mechanisms in place to prevent recurrence of the incident, including date of review of Center policies and procedures. g. Documentation of reports to Adult Protective Services, law enforcement, or the Department of	F 609		

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F 609 Continued From page 12 F 609

Health Professions, as appropriate..."

12/01/2020, Resident #5 was seen by the (PA) physician assistant for "... (c/o) complaints off burning upon urination. Nursing reports that she seems more confused today as well...Urinary tract infection with hematuria...urinalysis obtained earlier today, positive for (UTI) urinary tract infection-start Cipro 250mg..."

12/04/2020 8:07 a.m. (LPN) licensed practical nurse #4 documented "...was very confused and aggressive this AM. She accused staff of raping her and she also, scratched the (NA) nurse aide trying to help her to get on her chair as per her request."

The facility provided the surveyor with a copy of a handwritten document dated "12/4/2020" that had been signed by the (DON) director of nursing. Conversation held with (Resident #5) on 12/4/2020. Met with patient to discuss events from night before "staff raped me." Asked pt if she felt safe here in facility: Pt states she had been assaulted; when asked by who rsd states "I don't know his name, he's the night watchman." "His sister is my roommate and she is very powerful." Unable to give date of occurrence. Asked rsd to describe the man. Tall, large, crew cut, blonde. He told me he raped me those are his words not mine. I was asleep. (Resident #5) was confused and aggressive this morning. Currently, being treated for UTI recently started on Lexapro. Attempted to assess pt, she refuses. No employee matching this description employed. Roommate does not have family employed here.

04/01/2021, Resident #5 attended an out of facility appointment accompanied by a family

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F 609	Continued From page 13 member. While on this appointment Resident #5 stated to the staff that she had been abused by one of the male nursing home workers. 04/12/2021 11:58 a.m., the surveyor spoke with Resident #5 in their room. Resident #5 was alert and orientated to self. When asked if they had been abused by anyone Resident #5 stated I do not want to tell it all over again. Resident #5 did state it was one of the staff, a big male person, and it happened in the middle of the night. Resident #5 stated the person was white, they did not have a mask in place, and they did work at the facility. When asked if they had saw this person lately Resident #5 stated yes, I don't want to and stated she did not know the persons name. Resident #5 stated they told the head nurse and they fired the person. 04/12/2021 12:10 p.m., (CNA) certified nursing assistant #7 stated the resident was requiring more help due to becoming incontinent and that was a change for her. It was explained to her but I do not think she understood, she was complaining of being raped, and did not like a male person cleaning her. CNA #7 stated she reported the allegation to the nurse (no longer employed at the facility), the resident was not quiet about it, and they now had a female to work with the patient. 04/12/2021 12:20 p.m., the DON stated an FRI was not completed in December 2020, as the employee description did not match anyone working at the facility. The surveyor requested a list of all caucasian male employees currently employed at the facility. All of these employees were interviewed.	F 609		

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LPN #4 stated that one time the resident was rolling around the hallway talking to herself and they seemed to recall the resident accused ______ (first name only given) said she was being raped. Maybe when she was being changed she did not want to be changed. LPN #4 stated he mentioned this to a couple other employees and it was in the fall. LPN #4 stated it was absolutely false when I am there it is on my watch and I am a pain in the a**. I have a strict protocol if there was something going on I would know all the CNA's are great. Other staff #10 was asked if they were aware of any accusations the resident made. This staff stated the resident had not said anything to them directly but they had heard some of the nursing staff say she had said things when she was confused.

04/12/2021 3:10 p.m., other staff #6 obtained permission to speak with the surveyor from Resident #5. After receiving permission other staff #6 stated Resident #5 was at the office on 04/01/2021 and was asked a list of questions to include did she feel safe at home to which Resident #5 answered, no and stated a male employee abused her at _______ nursing home and he had since been fired. Other #6 stated the provider reached out to her and Resident #5 answered the questions the same way when she asked them. Other #6 stated the resident did not want to talk about the incident and got upset and stated it was over and done with. (APS) adult protective services was called. Other #6 stated there were no specifics about the male employee or the allegation. However, Resident #5 had told the provider they had fought back to include scratching and punching the male employee.

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F 609	Continued From page 15 04/12/2021 3:35 p.m., during a meeting with the administrator, DON, regional nurse consultant, and (ADON) assistant director of nursing. These staff were asked why an FRI was not completed. The administrator stated the DON spoke with Resident #5 and the Resident stated it was night watchman, they had no staff that matched that description, based on their observation, and the resident having a UTI no FRI was completed. 04/12/2021 4:00 p.m., these same staff stated the resident was their own RP so the family was not notified and the staff person with the same first name as LPN #4 referred to was a short person with brown/black hair. 04/13/2021 9:30 a.m., (APS) adult protective services worker #1 stated the facility had not reported this incident. 04/13/2021 9:53 a.m., the administrator and DON were asked other than speaking with the resident was any other investigation completed. The administrator replied, no, I do not think so based on what the resident told us. The administrator stated they had no male caucasian staff that were terminated in October, November, or December of 2020 and they did not have a night watchman. No further information regarding the facilities failure to report an allegation of abuse was provided to the survey team prior to the exit conference. This is a complaint deficiency.	F 609		
F 677 SS=D	ADL Care Provided for Dependent Residents	F 677		5/14/21

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F 677	Continued From page 16 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation the facility staff failed to ensure that a resident who was unable to carry out activities of daily living received the necessary care and services to maintain personal hygiene for 1 of 6 residents, Resident #3. The findings included: The facility staff failed to ensure Resident #3 received their baths/showers and that oral hygiene was completed. This was a closed record review. Resident #3's (EHR) electronic health record included, but was not limited to the following diagnoses, fracture of the right femur, chronic pain, and muscle weakness. Section C (cognitive patterns) of Resident #3's admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 11/26/2020 included a (BIMS) brief interview for mental status summary score of 11 out of a possible 15 points. Per the (RAI) resident assessment instrument manual a score of 8-12=moderately impaired. Section E (behavior) was coded to indicate the resident did not exhibit any behavioral symptoms. Section G (functional	F 677	F677 1. Resident #3 no longer resides in the center. 2. Current residents will be reviewed to determine completion of baths/showers and oral hygiene. Any issues will be corrected at the time of identification. 3. Current nursing staff will be educated regarding requirements for performing routine baths/showers and oral hygiene. Current residents will receive baths/showers per schedule and/or preference and daily oral hygiene. Nursing administration will review 10% sample of residents weekly x 4 weeks to ensure completion of bath, showers, and oral hygiene. Any issues will be corrected at the time of identification. 4. Process will be reviewed in next quarterly QA committee meeting. 5. 5/14/21 6. Amy Taylor, DON	

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status) was coded to indicate the resident required extensive assistance of one person (3/2) for bed mobility, dressing, toilet use, personal hygiene, and bathing. Resident #3 was coded as having no impairment in the upper extremity and impairment on one side of the lower extremity. The resident was coded as using a wheelchair for mobility. Section L (oral/dental status) was coded to indicate the resident had no dental issues.

Section E of the residents discharge MDS assessment with an ARD of 01/08/2021 was coded to indicate the resident did not have any rejection of care.

Resident #3's comprehensive care plan included the focus areas activities of daily (ADL) living self-care performance deficit, resistive to care, impaired cognition, actual fall prior to admission at risk for falls, pain acute right femur fracture, and potential for skin impairment. Interventions included, but were not limited to, resident is able to assist/as needed in the areas of am routine, bathing/showering, bed mobility, dressing, eating, personal hygiene/oral care, toilet use, and transfers. Allow the resident to make decisions about treatment regimen, confer with family/caregivers/responsible party regarding best approaches to patient, provide resident with opportunities for choice during care provision, cue reorient and supervise as needed, monitor intake and record every meal, keep skin clean and dry, lotion to dry skin, moisture barrier cream as needed for protection of skin, pericare with incontinence episodes, pressure reduction mattress, monitor and document for signs and symptoms of urinary tract infections.

A review of Resident #'3's (ADL) activities of daily

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living documentation for the month of 12/2020 revealed that the facility staff had not documented for a bath or shower on 12/02/2020, documented 1/8/8/-97 for 12/09/2020 per the preprinted code on this form a 1=no 8/8=activity did not occur, -97= not applicable, and for 12/23/2020 the ADL sheet was blank.

In the area of personal hygiene, the facility staff had not documented any data for the 7-3 shift on 12/02/2020, 12/23/2020, 12/27/2020, 12/29/2020, and 01/08/2021. For the 3-11 shift the facility staff had not documented any data for 12/06/2020, 12/09/2020, 12/10/2020, 12/15/2020, 12/16/2020, 12/17/2020, 12/21/2020, 12/23/2020, 12/24/2020, 12/25/2020, 12/28/2020, 12/29/2020, 01/02/2021, 01/07/2021, and 01/08/2021.

The clinical record included progress notes indicating the resident would pull away and/or refuse oral care. The facility did not provide any evidence of any alternate interventions that were attempted.

Resident #3 was sent to a local (ED) emergency department on 01/08/2021. At 9:27 p.m. LPN #1 documented the resident was departing the facility with (EMS) emergency medical services.

01/08/2021 9:32 p.m., "History and Physical" from admitting hospital read in part, "...Noted to have poor personal hygiene, question of neglect..."

03/30/2021 4:00 p.m., (CNA) certified nursing assistant #4 stated the resident would not let us brush her teeth, she got mad and refused oral care and the nurse was made aware. When asked about bathing CNA #4 stated the resident would be upset and when asked if they had any

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concerns regarding Resident #3 CNA #4 stated just that she refused oral care.

03/30/2021 4:08 p.m., CNA #5 stated the resident refused mouth care, her breath was bad, and they tried to use toothettes.

03/31/2021 8:50 a.m., (LPN) licensed practical nurse #1 was asked if they had any concerns when the resident was transported out to a local hospital on 01/08/2021. LPN #1 stated, yes the fact that she would not let us perform oral care. When asked if this resident refused their shower/bath LPN #1 stated the resident did not like to get up much.

04/01/2021 6:28 a.m., CNA #3 stated the resident did not refuse care they were just uncomfortable with pain and mouth care was completed on night shift.

04/01/2021 6:33 a.m., (RN) registered nurse #1 stated the resident always had a vague odor "her breath."

04/01/2021 7:25 p.m., LPN #3 stated the resident would pocket their medication and the CNA's were told to do oral care but she would turn away and that the resident's mouth was a concern. Seemed like she just did not want you messing with her and she would turn away.

04/02/2021 2:27 p.m., the administrator was made aware of the issue regarding the resident's ADL sheets being incomplete.

04/15/2021 9:05 a.m., LPN #5 stated the resident refused oral care, she refused a lot, once they saw something in the residents mouth maybe

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pudding and she cleaned the residents mouth, they were not sure if oral care was specifically documented in EHR, and that they believed the residents bottom teeth were partials. LPN #5 then added I am trying to remember but it has been a while.

After the interview with LPN #5 the administrator, DON, and ADON were asked if there was anywhere specifically oral care was documented. The administrator stated it was under personal hygiene and the CNA is expected to do oral care.

Hospital documentation:

01/09/2021 2:54 a.m., "...Pt's tongue, teeth, and roof of mouth appear to be covered in crust..."

01/09/2021 3:28 a.m., "Patients mouth swabbed and attempted to clean mucus out. Patient did not like it being in her mouth..."

01/09/2021, forensic nurse at the hospital documented the following "20:19 PM: At patient beside...Patient's son ______ was contacted by phone...gives verbal consent for forensic exam and photos...20:19 PM...General Appearance: Disheveled..."

The surveyor reviewed these pictures on 04/16/2021. Visible areas included, but were not limited to, dark debris present on Resident #3's bottom teeth, knee brace open with a stitch being visible above the residents right knee, steri strips were observed on the inside of the brace, the residents legs and heels were dry in appearance, toenails on the right and left foot were long and thick, and the right toenails had an orange appearance.

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F 677	Continued From page 21 The facility failed to provide the surveyor with any documentation to indicate they had tried alternate interventions in regards to oral care, that oral care had consistently been completed, or that a bath/shower had been provided on 12/02/2020, 12/09/2020, and 12/23/2020. This is a complaint deficiency.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure a resident received the treatment and care in regards to a recent fracture of the femur for 1 of 6 residents, Resident #3. The findings included: The facility staff failed to identify during weekly skin evaluations and communicate to the attending physician that Resident #3 had a stitch in place to their right leg. Resident #3 was treated at a local hospital after a decline in condition. This stitch was identified by the hospital staff.	F 684	F684 1. Resident #3 no longer resides in the center 2. Current residents with surgical wounds will be reviewed to ensure complete assessment of site and presence of physician orders for site care. Any issues will be corrected at the time of identification. 3. Current licensed nursing staff will be educated regarding surgical wound assessment and care. Surgical wounds will be routinely assessed and cared for according to physician orders. Nursing administration will observe residents with	5/14/21

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F 684	Continued From page 22 This was a closed record review. Resident #3's (EHR) electronic health record included, but was not limited to the following diagnoses, fracture of the right femur, chronic pain, and muscle weakness. Section C (cognitive patterns) of Resident #3's admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 11/26/2020 included a (BIMS) brief interview for mental status summary score of 11 out of a possible 15 points. Per the (RAI) resident assessment instrument manual a score of 8-12=moderately impaired. Section G (functional status) was coded to indicate the resident required extensive assistance of one person (3/2) for personal hygiene and bathing. Section M (skin conditions) was coded to indicate the resident had a pressure reducing device for bed and had surgical wounds. It was not coded to indicate the resident was receiving any surgical wound care. Resident #3's comprehensive care plan included the focus areas ADL activities of daily living self-care performance deficit, resistive to care, impaired cognition, actual fall prior to admission at risk for falls, pain acute right femur fracture, and potential for skin impairment. Interventions included, but were not limited to, resident is able to assist/as needed in the areas of am routine, bathing/showering, bed mobility, dressing, eating, personal hygiene/oral care, toilet use, and transfers. Allow the resident to make decisions about treatment regimen, confer with family/caregivers/responsible party regarding best approaches to patient, provide resident with opportunities for choice during care provision, cue	F 684	surgical wounds weekly X 4 weeks to ensure assessment is complete and site is being cared for per physician orders. Any issues will be corrected at the time of identification. 4. Process will be reviewed in next quarterly QA committee meeting. 5. 5/14 /21 6. Amy Taylor, DON	

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F 684	Continued From page 23 reorient and supervise as needed. Keep skin clean and dry, lotion to dry skin, and moisture barrier cream as needed for protection of skin. The EHR included weekly skin evaluations completed by the nursing staff. 11/20/2020-Right knee surgical incision and right outer thigh surgical incision present on admission, no drainage. Steri-strips in place. No sutures/staples present. . 11/26/2020-Skin intact, no wound(s) present. Right outer thigh surgical incision and right knee surgical incision. Steri-strips in place. No sutures/staples in place. 12/07/2020-Skin intact, no wound(s) present. 12/14/2020-Skin intact, no wound(s) present. 12/21/2020-Skin intact, no wound(s) present. 12/28/2020-Skin intact, no wound(s) present. 01/04/2021-Skin intact, no wound(s) present. 01/08/2021 Hospital transfer form-Page 2 of this document that referenced "Skin/Wound Care" was left blank. ADL documentation-Monitor Skin Observation for the months of 12/2020 and 01/2021. There was no documented data on the following shifts and days for 12/2020 and 01/2021. Day 7-3 shift-12/02, 12/23, 12/27, 12/29, and 01/08. Evening 3-11 shift-12/06, 12/09, 12/10, 12/15, 12/16, 12/17, 12/21, 12/23, 12/24, 12/25, 12/28, 12/29, 01/02, 01/07, and 01/08. Night 11-7 shift 12/01, 12/09, 12/16, 12/31, and 01/03. The facility provided the surveyor with a copy of a weekly skin evaluation completed at Resident #3's previous facility. This form was dated 11/18/2020 and identified Resident #3 as having	F 684		

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"Stitches intact and wound (OTA) open to air."

Resident #3 had an orthopedic appointment on 11/20/2020 the "REPORT OF CONSULTATION" did not include any documentation in reference to steri-strips or stitches. Recommendation was to follow-up in 8 weeks and may shower with wounds uncovered.

A telemed visit was completed on 12/31/2020 for surgical follow-up. The provider documented that the resident was seen via remote visit today for post op check and that the resident stated their pain was controlled with tylenol, they had progressed to a cane, and they are pleased with surgical outcome.

12/31/2020 14:18 (2:18 p.m.) LPN #1 documented "Resident had virtual visit appointment today with (PA) physician assistant _____ for Ortho Follow-up. Recommendations: Can continue to increase her activity within the limits of her pain. She is ok to shower with continued weightbearing as tolerated with common sense safety. I will plan to see her one year from the date of surgery..."

Resident #3 was transferred and admitted to a local hospital on 01/08/2021.

History and Physical from hospital with a date of 01/08/2021 9:51 p.m. "...patient was functional until 2 months ago when she had a fall (at home) resulting in right femur fracture. Had been bedridden since them. Noted to have poor personal hygiene, question of neglect..."

ED (emergency department) note 01/09/2021 2:54 a.m., "...Pt's had knee operation 2 months

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ago and there are steri strips and a suture still in place. Steri strips noted to be are adhered to skin..."

03/31/2021 9:43 a.m., forensic nurse at the admitting hospital. Stated they did not see the resident until the next day (01/09/2021), the resident had a stitch in her right knee or leg, and a few steri strips in place. Later that morning when asked what prompted the hospital to request pictures of Resident #3 this nurse stated it was a concern from the family and medical staff regarding elder abuse.

04/01/2021 6:28 a.m., (CNA) certified nursing assistant #3 stated they did not remember any sutures or strips and that Resident #3 had a brace in place to their left leg. (Resident #3 wore this brace to their right leg).

04/15/2021 9:05 a.m., (LPN) licensed practical nurse #5 stated they did not recall any steri strips or stitches.

04/16/2021 3:36 p.m., medical records employee from orthopedic practice reviewed the residents record and stated it did not look like they removed any stitches and that it is usually stated that. This staff stated that the 11/20/2020 visit was Resident #3's first visit.

04/19/2021 9:45 a.m., the administrator and (DON) director of nursing were made aware that the hospital staff had identified a stitch in place above the residents right knee.

04/19/2021 4:33 p.m., the administrator stated the residents telemed appointment on 12/31/2020 was a telephone visit and did not include any

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F 684	Continued From page 26 video. No further information regarding this issue was provided to the survey team prior to the exit conference. This is a complaint deficiency.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that a resident who was unable to carry out activities of daily living received the necessary care and services to maintain foot care for 1 of 6 residents, Resident #3. The findings included: The facility staff failed to ensure Resident #3 received foot care. The resident's toenails on both feet were thick and long. This was a closed record review.	F 687	F687 1. Resident #3 no longer resides in the center. 2. Current residents were observed to ensure foot care has been received. Any issues will be corrected at the time of identification. 3. Current nursing staff will be educated regarding requirements for performing foot care. Current residents will receive foot care on a routine basis and as needed to include podiatry visits. Nursing administration will review 10% sample of residents weekly X 4 weeks to ensure	5/14/21

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Resident #3's (EHR) electronic health record included, but was not limited to the following diagnoses, fracture of the right femur, prediabetes, chronic pain, and muscle weakness.

Section C (cognitive patterns) of Resident #3's admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 11/26/2020 included a (BIMS) brief interview for mental status summary score of 11 out of a possible 15 points. Per the (RAI) resident assessment instrument manual a score of 8-12=moderately impaired. Section G (functional status) was coded to indicate the resident required extensive assistance of one person (3/2) for personal hygiene and bathing.

Section E of the residents discharge MDS assessment with an ARD of 01/08/2021 was coded to indicate the resident did not have any rejection of care.

Resident #3's comprehensive care plan included the focus areas ADL activities of daily living self-care performance deficit, resistive to care, impaired cognition, actual fall prior to admission at risk for falls, pain acute right femur fracture, and potential for skin impairment. Interventions included, but were not limited to, resident is able to assist/as needed in the areas of am routine, bathing/showering, bed mobility, dressing, eating, personal hygiene/oral care, toilet use, and transfers. Allow the resident to make decisions about treatment regimen, confer with family/caregivers/responsible party regarding best approaches to patient, provide resident with opportunities for choice during care provision, cue reorient and supervise as needed, keep skin

F 687

completion of foot care. Any issues will be corrected at the time of identification.
4. Process will be reviewed in next quarterly QA committee meeting.
5. 5/14/21
6. Amy Taylor, DON

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F 687	Continued From page 28 clean and dry, lotion to dry skin, moisture barrier cream as needed for protection of skin, and pressure reduction mattress. Resident #3 was discharged to a local hospital on 01/08/2021. The forensic nurse obtained pictures on 01/09/2021 due to a concern of "elder neglect." The surveyor reviewed these pictures on 04/16/2021. Resident #3's legs and heels were observed to be dry in appearance, toenails on the right and left foot were long and thick, and the toenails on the residents right foot had an orange appearance. 04/19/2021, the administrator notified the surveyor that Resident #3 was not seen by the podiatrist while at the facility. The podiatrist had visited on 11/25/2020 and the resident was discharged prior to the next scheduled visit. 04/19/2021 4:30 p.m., the administrator and RNC (regional nurse consultant) stated the nurse would have been responsible for trimming the residents toenails. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 687		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		5/14/21

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F 842	Continued From page 29 agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained	F 842		

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F 842	Continued From page 30 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 3 of 4 residents, Resident #2, #4 and #3. The findings included: 1. For Resident #2 the facility staff failed to document that treatments were completed as ordered as evidenced by blank areas on the eTAR's (electronic treatment administration record). Resident #2's face sheet listed diagnoses which included but not limited to acute respiratory failure, pneumonia, emphysema, anemia, and history of COVID-19.	F 842	F842 1. Resident #2, #3, and #4 no longer reside in the center. 2. Current residents treatment administration records were reviewed to ensure completion of treatments and documentation. Current residents Activity of Daily Living records were reviewed to ensure completion and documentation. Any issues will be corrected at the time of identification. 3. Current nursing staff will be educated regarding requirements for documenting treatments as ordered and completion of ADLS with documentation. Current residents will receive treatments as ordered and ADL care daily. Nursing administration will review 10% sample of	

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F 842	Continued From page 31 The admission MDS (minimum data set) with an ARD (assessment reference date) of 03/10/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Resident #2's comprehensive care plan was reviewed and contained a care plan for "The resident has a pressure ulcer to Left buttock" with a goal of "The resident's Pressure ulcer will show signs of healing and remain free from infection by/through review date". Interventions for this care plan included "Administer treatments as ordered and monitor for effectiveness". The comprehensive care plan also contained a care plan for "The resident has altered respiratory status/difficulty breathing r/t (related to) acute respiratory failure, interstitial emphysema, OSA (obstructive sleep apnea)". Interventions for this care plan included "Monitor for s/sx (sign/symptoms) of respiratory distress and report to MD as needed". Resident #2's physician's order summary for the month of March 2021 was reviewed and contained orders, which read in part "Apply Bag Balm to Bilateral Legs and Feet topically every evening shift for Dry skin", Cleanse Left Buttock with NS (normal saline), pat dry, place Fibracol, and cover with Allevyn, every evening shift", "Oxygen Therapy-Oxygen at 8 liters per minute via nasal cannula every shift", and "Wean 02, maintain sats above 92% on RA (room air) every shift". Resident #2's eTAR's were reviewed and contained entries as above. The entry for "apply bag balm" was not initialed on 03/23/21, the entry for "cleanse left buttock ..." was not initialed on	F 842	residents weekly X 4 weeks to ensure completion of treatments and ADL care. Any issues will be corrected at the time of identification. 4. Process will be reviewed in next quarterly QA committee meeting. 5. 5/14/21 6. Amy Taylor, DON	

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03/23/21, the entry for "Oxygen therapy ..." was not initialed on 03/23/21-evening, 03/25/21- night and 03/29/21-night. The entry for "wean 02 ..." was not initialed on 03/25/21-night and 03/29/21-night".

Surveyor spoke with Resident #2 on 03/31/21 at approximately 8:15 am. Resident observed using oxygen at 5 liters per minute. Resident stated that staff have been turning oxygen down to try and get him off of oxygen. Surveyor asked Resident #2 if he was receiving treatments to buttocks and Resident stated "they do it every morning and it's getting better"

Surveyor spoke with ADON (assistant director of nursing) on 03/31/21 at approximately 9:30 am. Surveyor asked ADON if the treatment sheet should be initialed when treatments are completed, and ADON stated that they should.

The concern of not ensuring treatment sheets were initialed was discussed with the administrator, ADON and regional nurse consultant during a meeting on 03/31/21 at approximately 11:30 am.

No further information was provided prior to exit.

2. For Resident #4 the facility staff failed to document that treatments were completed as ordered as evidenced by blank areas on the eMAR (electronic medication administration record) and eTAR (electronic treatment administration record).

Resident #4's face sheet listed diagnoses which included, but not limited to metastatic prostate cancer, acute embolism, chronic kidney disease,

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diabetes mellitus type 2, urinary retention, chronic obstructive pulmonary disease, and hypertension.

Resident #4's admission MDS (minimum data set) with an ARD (assessment reference date) of 01/21/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. Section O, special treatments, procedures and programs, coded the resident as receiving oxygen therapy.

Resident #4's comprehensive care plan was reviewed and contained a care plan for "The resident has altered respiratory status/difficulty breathing r/t (related to) COPD (chronic obstructive pulmonary disease), resp failure, oxygen dependent". Interventions for this care plan included "Oxygen as ordered" and "Monitor for s/sx (signs/symptoms) of respiratory distress and report to MD as needed".

Resident #4's physician's order summary for the month of January 2021 was reviewed and contained orders, which read in part "oxygen therapy-oxygen at 2 liters per minute via nasal cannula Dx (diagnosis): COPD (chronic obstructive pulmonary disease) every shift", "respiratory evaluation every shift", and "Bladder scan every shift. I & O (in and out) cath if > (greater than) 350 ml every shift".

Resident #4's eTAR for January 2021 was reviewed and contained entries which read in part, "oxygen therapy-oxygen at 2 liters per minute via nasal cannula Dx (diagnosis): COPD (chronic obstructive pulmonary disease) every shift" and "Bladder scan every shift. I & O (in and out) cath if > (greater than) 350 ml every shift". The entry for oxygen therapy was not initialed on

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01/16/21 for evening shift. The entry for bladder scan was not initialed on 01/22/21-nights, 01/25/21-evenings or 01/27/21-days. Resident #4's eMAR for January 2021 was reviewed and contained an entry, which read in part "respiratory evaluation every shift". This entry was not initialed on 01/22/21 for day shift.

Surveyor spoke with ADON (assistant director of nursing) on 03/31/21 at approximately 9:30 am. Surveyor asked ADON if the eMAR's and eTAR's should be initialed when treatments are completed, and ADON stated that they should.

The concern of not ensuring eMAR's/eTAR's were initialed was discussed with the administrator, ADON and regional nurse consultant during a meeting on 03/31/21 at approximately 11:30 am.

No further information was provided prior to exit.
3. For Resident #3, the facility staff failed to complete the residents (ADL) activity of daily living documentation for the months of 12/2020 and 01/2021.

This was a closed record review.

Resident #3's (EHR) electronic health record included, but was not limited to the following diagnoses, fracture of the right femur, chronic pain, and muscle weakness.

Section C (cognitive patterns) of Resident #3's admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 11/26/2020 included a (BIMS) brief interview for mental status summary score of 11 out of a possible 15 points. Per the (RAI) resident

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F 842	Continued From page 35 assessment instrument manual a score of 8-12=moderately impaired. Section E (behavior) was coded to indicate the resident did not exhibit any behavioral symptoms. Section G (functional status) was coded to indicate the resident required extensive assistance of one person (3/2) for bed mobility, dressing, toilet use, personal hygiene, and bathing. Resident #3 was coded as having no impairment in the upper extremity and impairment on one side of the lower extremity. The resident was coded as using a wheelchair for mobility. Section L (oral/dental status) was coded to indicate the resident had no dental issues. Section E of the residents discharge MDS assessment with an ARD of 01/08/2021 was coded to indicate the resident did not have any rejection of care. A review of Resident #'3's ADL documentation for the months of 12/2020 and 01/2021 revealed that the facility staff had failed to thoroughly complete these sheets for the areas of bathing, bed mobility, dressing, locomotion on unit, personal hygiene, toilet use, eating, locomotion off unit, transferring, walk in corridor, walk in room, bowel/bladder elimination, kardex, behavior symptoms, skin observations, swallowing, eating, bedtime snacks, activity attendance, and vitals. No information regarding the missing documentation was provided to the survey team prior to the exit conference on 04/19/2021.	F 842		