DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

(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 9/28/2021 through 10/5/2021. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The	E 037	1. All facility staff on duty at time concern was initiated received immediate education. 2. All staff not available at time of in-service previously initiated during inspection received required education and documentation completed accordingly. 3. DON or designee will educate all new facility staff on emergency preparedness education. 4. DON or designee will audit 10% of current and new staff to ensure compliance of receipt of mandatory emergency preparedness training. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator

(X6) DATE 11/22/2021

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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E 037	Continued From page 1 hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF	E 037		

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E 037	Continued From page 2 must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The	E 037		

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E 037	Continued From page 3 CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 4 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review it was determined the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documented evidence of annual emergency preparedness training for the staff. The findings include: The Emergency Preparedness Plan was reviewed with ASM (administrative staff member) #1, the administrator, on 10/4/2021 at 2:02 p.m. ASM #1 failed to provide evidence of annual emergency training for the five CNA (certified nursing assistants) employee records reviewed. On 10/4/2021 at 4:17 p.m. RN (registered nurse) #3, the quality assurance and infection preventionist nurse, provided training documents	E 037		

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E 037	Continued From page 5 but these training documents did not have emergency preparedness training. An interview was conducted with RN #4, the staffing educator, on 10/5/2021 at 9:36 a.m. When asked where the documentation of annual emergency preparedness training was, RN #4 stated she did not have any to present. RN #4 stated she does not have access to the computerized training program where that would have been assigned to the staff to complete. RN #4 started employment at the facility in March 2021 as the staffing educator. ASM #2, the director of nursing, was made aware of the above concern on 10/5/2021 at 1:58 p.m. No further information was provided prior to exit.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/28/21 through 9/30/21 and 10/4/21 through 10/5/21. Five complaints were investigated during the survey; VA00053224, VA00052620, VA00052665, VA00052261, and VA00052289. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 225 certified bed facility was 192 at the time of the survey. The survey sample consisted of 60 current resident reviews and 24 closed record reviews.	F 000		
F 559 SS=E	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his	F 559	#1. Residents #510, 29, 511, 512, 513, 383, 514, 516, 517, 515 are no longer residing residents in the center. Residents # 111, 139 153, 30, 75, 26, 66 and 13 have not participated in a room move since completion of centers inspection	

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F 559	Continued From page 6 or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide written notice to the resident and or resident representative, including the reason for the change, before the resident's room or roommate in the facility is changed for eighteen of 84 residents in the survey sample, (Residents #510, #111, #29, #153, #30, #75, #26, #512, #66, #513, #139, #515, #13, #516, #517, #511, #514 and #383). The facility staff failed to evidence written notification for multiple room changes were provided to the resident represenative and or Residents #510, #111, #29, #153, #30, #75, #26, #512, #66, #513, #139, #515, #13, #516, #517, #511, #514 and #383. The findings include: 1. The facility staff failed to evidence written notice of the room change provided to the Resident #510/RR (resident representative) for	F 559	2. All resident's participating in room moves since 09/01/2021 reviewed to ensure written notification provided for room change. 3. DON or designee will education all facility staff on current policy for providing written notification to residents and/or responsible [representative prior to completion of room change. 4. DON or designee will audit 10% of all residents to ensure prior to completion of room change, written notification was completed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance Committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 559	Continued From page 7 room transfers on 6/2/21, 6/30/21, 7/19/21, and 8/5/21. Resident #510 was admitted to the facility on 11/10/20 with diagnoses including history of a stroke, diabetes, and deafness. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/13/21, Resident #510 was coded as being severely cognitively impaired for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status). He was coded as being highly impaired for hearing, and as sometimes understood by others and sometimes understanding others for communication. He was coded as having no speech. A review of Resident #510's clinical record revealed he was transferred to a new room in the facility on 6/2/21, 6/30/21, 7/19/21, and 8/5/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative). On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete. On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to	F 559		

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work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical

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record, whether it be patient choice or a clinical need.

A review of the facility policy, "Room Change/Roommate Assignment," revealed, in part: "Changes in room or roommate assignment shall be made when the facility deems it necessary or when the resident requests the change.
Policy Interpretation and Implementation
1. The facility reserves the right to make resident room changes or roommate assignments when the facility deems it necessary or when the resident requests the change.
2. Prior to changing a room or roommate assignment all parties involved in the change/assignment (e.g., res-idents and their representatives (sponsors)) will be given a _____ (sic) hour/day advance notice of such change.
3. Advance notice of a roommate change will include why the change is being made and any information that will assist the roommate in becoming acquainted with his or her new roommate.
4. Unless medically necessary or for the safety and well-being of the resident(s), a resident will be provided with an advance notice of the room change. Such notice will include the reason(s) why the move is recommended...Documentation of a room change is recorded in the resident's medical record."

No further information was provided prior to exit.

Complaint Deficiency

2. The facility staff failed to evidence written notice of the room change provided to Resident #111and or the resident/RR (resident

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F 559	Continued From page 10 representative) for room transfers on 5/25/21, 6/1/21, and 6/2/21. Resident #111 was admitted to the facility on 5/4/21 with diagnoses including a left hip fracture, chronic obstructive pulmonary disease (lung disease), and Alzheimer's disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/28/21, Resident #111 was coded as having severe impairment for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status). A review of the resident's clinical record revealed they were transferred to a new room in the facility on 5/25/21, 6/1/21, and 6/2/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative) was requested. On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete. On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the	F 559		

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resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

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On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

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Complaint Deficiency

3. The facility staff failed to evidence written notice of the room change provided to Resident #29/RR (resident representative) for room transfers on 5/27/21, and 6/7/21.

Resident #29 was admitted to the facility on 10/28/20 with diagnoses including an abdominal hernia and depression. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/21, Resident #29 was coded as being severely impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status).

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 5/27/21, and 6/7/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 559	Continued From page 13 days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate. On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together." On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident. On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see	F 559		

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the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

4. The facility staff failed to evidence written notice of the room change provided to Resident #153/RR (resident representative) for room transfers on 5/26/21, 6/2/21, and 9/11/21.

Resident #153 was admitted to the facility on 2/11/21, and most recently readmitted on 3/12/21, with diagnoses including paralysis of arms and legs, bipolar disorder with manic features, severe psychotic features, and post-traumatic stress disorder. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/21, Resident #153 was coded as being moderately cognitively impaired for making daily decisions, having scored 12 out of 15 on the BIMS.

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 5/26/21, 6/2/21, and 9/11/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social

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workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of

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F 559	Continued From page 16 the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident. On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need. No further information was provided prior to exit. Complaint Deficiency 5. The facility staff failed to evidence written notice of the room change provided to Resident #30/RR (resident representative) for room transfers on 6/29/21 and 8/20/21. Resident #30 was admitted to the facility on 5/28/21 and most recently readmitted on 8/20/21, with diagnoses including a brain bleed, dementia without behaviors, heart failure, and chronic obstructive pulmonary disease (lung disease). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/13/21, Resident #30 was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS. A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/29/21 and 8/20/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident	F 559		

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F 559	Continued From page 17 representative) was requested. On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete. On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate. On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together." On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources.	F 559		

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ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

6. The facility staff failed to evidence written notice of the room change provided to Resident #75/RR (resident representative) for room transfers on 6/3/21 and 7/22/21.

Resident #75 was admitted to the facility on 1/23/20 with diagnoses including a spinal injury and paraplegia (paralysis of legs). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/28/21, Resident #75 was coded as being moderately cognitively impaired for making daily decisions, having scored nine out of 15 on the BIMS (brief interview for mental status).

A review of the resident's clinical record revealed

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they were transferred to a new room in the facility on 6/3/21 and 7/22/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

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On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

7. The facility staff failed to evidence written notice of the room change provided to Resident #26/RR (resident representative) for room transfers on 7/18/21, and 7/19/21.

Resident #26 was admitted to the facility on 8/20/20 with a diagnosis of dementia with behaviors. On the most MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 7/12/21, Resident #26 was

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coded as being severely cognitively impaired for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status).

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 7/18/21, and 7/19/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative).

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She

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stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

8. The facility staff failed to evidence written notice of the room change provided to Resident #512/RR (resident representative) for room transfers on 6/3/21 and 6/5/21.

Resident #512 was admitted to the facility on 5/12/21, and most recently readmitted on 7/9/21,

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F 559	Continued From page 23 with diagnoses including dementia without behaviors and sepsis (body-wide infection). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/18/21, Resident #512 was coded as being severely impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/3/21 and 6/5/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative) was requested. On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete. On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to	F 559		

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notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

9. The facility staff failed to evidence written notice of the room change provided to Resident

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#66/RR (resident representative) for room transfers on 6/21/21, 7/22/21, 8/23/21, and 8/24/21.

Resident #66 was admitted to the facility on 12/7/18 with a diagnosis of dementia with behaviors. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/5/21, Resident #66 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS.

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/21/21, 7/22/21, 8/23/21, and 8/24/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team

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meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

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No further information was provided prior to exit.

Complaint Deficiency

10. The facility staff failed to evidence written notice of the room change provided to Resident #513/RR (resident representative) for room transfers on 6/3/21.

Resident #513 was admitted to the facility on 5/21/21, and most recently readmitted on 6/2/21, with diagnoses including end stage kidney disease (dialysis dependent), chronic obstructive pulmonary disease (lung disease), and morbid obesity. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/8/21, Resident #513 was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS (brief interview for mental status).

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/3/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

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F 559	Continued From page 28 On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate. On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together." On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident. On 10/4/21 at 5:06 p.m., ASM #1, the	F 559		

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administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

11. The facility staff failed to evidence written notice of the room change provided to Resident #139/RR (resident representative), and failed to evidence orientation of the resident to the new room/roommate for room transfers on 6/3/21, and 7/5/21.

Resident #139 was admitted to the facility on 9/14/20 with diagnoses including schizoaffective disorder, dementia with behaviors, and psychotic disorder. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/8/21, Resident #139 the resident was coded as being severely cognitively impaired for making daily decisions, having scored two out of 15 on the BIMS (brief interview for mental status).

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/3/21, and 7/5/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative) roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was

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interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM

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#2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

12. The facility staff failed to evidence written notice of the room change provided to Resident #515/RR (resident representative) for room transfers on 6/2/21.

Resident #515 was admitted to the facility on 4/9/21 with diagnoses including back bone fracture and history of a stroke. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/13/2, Resident #515 was coded as being severely cognitively impaired for making daily decisions, having scored six out of 15 on the BIMS (brief interview for mental status).

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/2/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and

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evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private

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pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

13. The facility staff failed to evidence written notice of the room change provided to the Resident #13/RR (resident representative) for room transfers on 6/2/21, 6/30/21, 8/21/21, 9/13/21, and 9/15/21.

Resident #13 was admitted to the facility on 2/27/21 with diagnoses including chronic obstructive pulmonary disease (lung disease), diabetes, and alcohol abuse. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/1/21, Resident #13 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief

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interview for mental status).

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/2/21, 6/30/21, 8/21/21, 9/13/21, and 9/15/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative) was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social

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workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

14. The facility staff failed to evidence written notice of the room change provided to Resident #516/RR (resident representative) for room transfers on 6/1/21.

Resident #516 was admitted to the facility on 2/27/20, and most recently readmitted on 5/24/21, with diagnoses including history of stroke with

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right sided paralysis, bipolar disorder, and schizophrenia. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 5/8/21, Resident #516 was coded as having no cognitive impairment for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status).

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/1/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is

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required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

15. The facility staff failed to evidence written

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F 559	Continued From page 38 notice of the room change provided to Resident #517/RR (resident representative) for room transfers on 6/3/21 and 7/22/21. Resident #517 was admitted to the facility on 8/30/20 with a diagnosis of Alzheimer's disease. On the most recent MDS (minimum data set), an annual assessment with an ARD of 8/10/21, Resident #517 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). A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/3/21 and 7/22/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative) was requested. On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete. On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the	F 559		

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reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

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Complaint Deficiency

16. The facility staff failed to evidence written notice of the room change provided to Resident #511/RR (resident representative) for room transfers on 6/4/21.

Resident #511 was admitted to the facility on 5/28/21 with diagnoses including a left total knee replacement and high blood pressure. He was discharged from the facility on 8/9/21. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 6/3/21, Resident #511 was coded as having no impairment for making daily decisions, having scored a 15 out of 15 on the BIMS (brief interview for mental status).

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/4/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the

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F 559	Continued From page 41 residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate. On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together." On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns regarding room transfers for this resident. On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the	F 559		

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transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency

17. The facility staff failed to evidence written notice of the room change provided to Resident #514/RR (resident representative) for room transfers on 6/5/21, 7/6/21, and 7/23/21.

Resident #514 was admitted to the facility on 4/16/21 with diagnoses including sepsis (body-wide infection), osteomyelitis (bone infection), morbid obesity, and paraplegia (paralysis of legs). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/22/21, Resident #514 was coded as being cognitively intact for making daily decisions, having scored 13 out of 15.

A review of the resident's clinical record revealed they were transferred to a new room in the facility on 6/5/21, 7/6/21, and 7/23/21. On 9/29/21 at 4:30 p.m., evidence of written notice of the room change provided to the resident/RR (resident representative), and evidence orientation of the resident to the new room/roommate was requested.

On 9/30/21 at 10:57 a.m., OSM (other staff member) #5, the admissions coordinator, was interviewed. When asked if she has a role in internal room transfers, she stated the social workers are in charge of room transfers. She stated the social workers inform her of residents

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who need a room change, and will inform her once the change is complete.

On 10/4/21 at 10:34 a.m., OSM #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to the residents' room changes before she started to work. She stated she has a form she uses to track room transfers. She stated this should be a decision made by the team, and this team meeting should be documented. She stated the resident/RR should be notified and told the reason for the transfer. OSM #4 stated she orients the resident to the new room, and determines room compatibility. She stated she is required to document everything she does to notify a resident/RR and to prepare the resident for a new room/roommate.

On 10/4/21 at 12:45 p.m., LPN (licensed practical nurse) #10, a unit manager, was interviewed. She stated room changes are managed by the social workers. LPN #10 stated, "They try to make sure we have people paired properly together."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated all rooms in the facility are certified to house residents with either private pay, Medicare, or Medicaid as payer sources. ASM #2 stated residents/RRs should be notified of room changes. She stated a room change is usually prompted by a resident request, an isolation requirement, or a roommate issue. ASM #2 stated there is usually a conversation among the team, and the social worker is in charge of the process, and of documenting the process. At this time, ASM #2 was informed of the concerns

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regarding room transfers for this resident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the resident should have had the opportunity to meet the new roommate and see the new room. ASM #1 stated the reason for the transfer should be documented in the clinical record, whether it be patient choice or a clinical need.

No further information was provided prior to exit.

Complaint Deficiency
18. The facility staff failed to provide written notification to Resident #383 and or the responsible party for a room change on 5/27/2021.

Resident #383 was admitted to the facility with diagnoses that included but were not limited to fracture of left femur (1) and major depressive disorder (2). Resident #383's most recent MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 6/5/2021, coded Resident #383 as scoring a 15 on the brief interview for mental status (BIMS) scale, 15- being cognitively intact for making daily decisions.

The admission record for Resident #383 documented Resident #383's son as their responsible party, power of attorney and emergency contact.

The census list for Resident #383 documented a room change for Resident #383 on 5/27/2021 at 14:49 (2:49 p.m.).

The comprehensive care plan for Resident #383

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dated 6/1/2021 documented in part, "Immunological: [Name of Resident #383] at risk for acquisition of CRE (carbapenem-resistant enterobacteriaceae) (3) related to possible exposure. Date Initiated: 06/01/2021; Revision on: 06/14/2021."

The progress notes for Resident #383 documented in part the following:

* "5/28/2021 16:09 (4:09 p.m.) Note Text: Resident continues on abt (antibiotic) for uti (urinary tract infection). Resident remains afebrile. n.o. (new order) rectal swab. RP (responsible party) aware. Resident refuses to close rm (room) door. Resident not easily redirected. Resident toilets self in room. No distress noted."
* "5/28/2021 17:20 (5:20 p.m.) Note Text: Writer spoke with RP and Resident, who confirms Resident is a full code status."
* "5/30/2021 11:51 (11:51 a.m.) Note Text: Writer requested to come to Resident's room to speak with Resident. Writer spoke with resident in regards of concerns of current contact precaution status. Writer educated Resident on the meaning of contact precautions and why she was currently on contact precautions. Questions answered to Resident's satisfactory. Resident also stated that "I want to know everything that is going on with me." Writer assured Resident once the results of rectal swab were obtained MD (medical doctor) /nurse would notify her. Writer did inform Resident that unfortunately, it was a holiday weekend and there may be a delay in obtaining the results, resident verbalized understanding."

"5/31/2021 10:45 (10:45 a.m.) Note Text: Resident alert and verbal with some confusion. Resident continues on contact precautions.

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F 559	Continued From page 46 Awaiting rectum culture results. Resident refuses to close room door. Resident requests to come out of room writer educated resident. Resident voiced no further concerns." "6/1/2021 10:41 (10:41 a.m.) Note Text: Resident continues on contact precautions. Rectal culture not in at this time. Resident denies pain or discomfort at this time. Writer received call from son r/t (related to) time in adl (activities of daily living) care. Writer notified son it was not day shift per resident it happened on another shift. Writer will notify UM (unit manager) with further details. At this time resident tolerated therapy and assisted as needed by staff." "6/1/2021 11:23 (11:23 a.m.) Note Text: Staff reported on 5/27/2021 resident had during night entered another room in which resident was in contact precautions. Facility reported to [Name of health department] for further guidance. Initial recommendation resident exposure was minimal and did not warrant need for surveillance. Upon further evaluation, resident utilizing shared bathroom, decision to conduct surveillance through use of rectal swab. Resident son/RP [Name of RP] aware, NP (nurse practitioner) [Name of NP] aware. [Name of local health department contact] aware, results pending." The clinical record for Resident #383 failed to evidence documentation of notification of the responsible party regarding the room change on 5/27/2021. On 10/4/2021 at 10:26 a.m., ASM (administrative staff member) #2, the director of nursing stated that the social worker named in the complaint no longer worked at the facility. On 10/4/2021 at 11:36 a.m., an interview was	F 559		

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conducted with LPN (licensed practical nurse) #8. LPN #8 stated that they did not recall any conversations with Resident #383's responsible party notifying them of the room change.

On 10/4/2021 at 12:54 p.m., an interview was conducted with OSM (other staff member) #5, the admissions coordinator. OSM #5 stated that they had multiple conversations with Resident #383's responsible party regarding requests to have a private room. OSM #5 stated that when a resident required a room change for isolation purposes the nurses would contact the social worker to contact the responsible party. OSM #5 stated that there were currently no social workers in the facility who worked there in May and June of 2021.

On 10/4/2021 at 2:50 p.m., an interview was conducted with LPN #12. LPN #12 stated that they worked the night shift (11:00 p.m.-7:00 a.m.) when Resident #383 was moved to another room. LPN #12 stated that Resident #383 was new to the facility and had some episodes of confusion. LPN #12 stated that a CNA (certified nursing assistant) had reported to them that Resident #383 had entered into a residents room who was on isolation for CRE by mistake and possibly been exposed by using a shared bathroom so they had moved Resident #383 to another room and placed them on isolation. LPN #12 stated that they did not recall any conversations with Resident #383's responsible party regarding the room change.

On 10/4/2021 at 5:15 p.m., an interview was conducted with RN (registered nurse) #3, the infection preventionist. RN #3 stated that Resident #383 had wandered into another

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resident's room who was on isolation for CRE. RN #3 stated that they had consulted with the local health department who recommended Resident #383 be placed on isolation as a precaution and a rectal swab be completed. RN #3 stated that social services notified responsible parties of room changes. RN #3 stated that if residents were moved during the night the social worker called the responsible party in the morning to notify them of the room change and documented in the progress note.

On 10/5/2021 at 12:30 p.m., an interview was conducted with OSM #4, the director of social services. OSM #4 stated that when a resident was transferred to another room in the facility a transfer form was completed and sent to the responsible party. OSM #4 stated that the physician was notified and the resident and responsible party were notified of the transfer. OSM #4 stated that the resident was oriented to the new room and new roommate if applicable prior to the move. OSM #4 stated that if the move were for infection control purposes the process happened quickly but the process was the same. OSM #4 stated that they had only been at the facility for a few days and were only able to speak to their process and not what the previous social worker followed.

On 10/5/2021 at 8:23 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that they were unsure when Resident #383 was moved to another room. ASM #2 stated that they would review the clinical record and see if they were able to evidence documentation of notification of the responsible party of the room change on 5/27/2021.

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On 10/5/2021 at 12:19 p.m., ASM #2, the director of nursing stated that they were unable to locate any evidence of notification of the responsible party for the room change on 5/27/2021.

On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM (administrative staff member) #2 for the facility policy on inter-facility room transfers and notification of the responsible party.

The facility policy, "Room Change/Roommate Assignment" dated May 2017 documented in part, "...Unless medically necessary or for the safety and well-being of the resident(s), a resident will be provided with an advance notice of the room change. Such notice will include the reason(s) why the move is recommended...Documentation of a room change is recorded in the resident's medical record..."

The facility policy, "Change in a Resident's Condition or Status" dated May 2017 documented in part, "...4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when:
...c. There is a need to change the resident's room assignment..."

On 10/5/2021 at approximately 1:15 p.m., ASM (administrative staff member) #2, the director of nursing was made aware of the above concern.

No further information was presented prior to exit.

Complaint Deficiency

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F 559	Continued From page 50 References: 1. Femur fracture: a fracture (break) in the femur in leg. It is also called the thigh bone. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm. 2. Major depressive disorder: is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm. 3. CRE stands for carbapenem-resistant Enterobacterales. Enterobacterales are an order of germs, specifically bacteria. Many different types of Enterobacterales can develop resistance, including Klebsiella pneumoniae and Escherichia coli (E. coli). These bacteria can cause infections including pneumonia, bloodstream infections, urinary tract infections, wound infections, and meningitis. CRE are a major concern for patients in healthcare settings because they are resistant to carbapenem antibiotics, which are considered the last line of defense to treat multidrug-resistant bacterial infections. Often, high levels of antibiotic resistance in CRE leave only treatment options that are more toxic and less effective. This information was obtained from the website: https://www.cdc.gov/hai/organisms/cre/cre-patients.html	F 559		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580	1. Resident #383 no longer resides in the facility.	

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F 580	Continued From page 51 §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580	2. All current residents residing in center reviewed to ensure notification of responsible representative for all incidents and changes of condition from since 09/01/2021. 3. DON or designee will educate all facility nursing staff on centers policy for notification of Responsible representative post incidents and changes of condition. 4. DON or designee will audit 10% of resident change of condition and incidents to ascertain notification of RR following event weekly times 4 weeks and monthly times 2 to ensure facility maintains proper notification. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 580	Continued From page 52 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and facility document review and in the course of a complaint investigation it was determined that the facility staff failed to notify the responsible party of an fall and physician orders for diagnostic testing for one of 84 residents in the survey sample, Resident #383. The facility staff failed to evidence Resident #383's responsible party was notified on Resident #383's fall on 6/2/21 and the physician order for an x-ray of the resident's left knee. The findings include: Resident #383 was admitted to the facility with diagnoses that included but were not limited to fracture of left femur (1) and major depressive disorder (2). Resident #383's most recent MDS (minimum data set), a discharge assessment with an ARD (assessment reference date) of 6/5/2021, coded Resident #383 as scoring a 15 on the brief interview for mental status (BIMS) scale, 15- being cognitively intact for making daily decisions. Section J documented Resident #383 having one fall without injury since admission. The admission record for Resident #383	F 580		

F 580 Continued From page 53 F 580

documented Resident #383's son as their responsible party, power of attorney and emergency contact.

The comprehensive care plan for Resident #383 dated 5/28/2021 documented in part, "At risk for falls due to history of falls, left hip fracture. Date Initiated: 05/28/2021, Revision on: 06/14/2021." Under "Interventions/Tasks" it documented in part, "Gripper socks on at all times when out of bed as tolerated. Date Initiated: 06/03/2021" and "Encourage to transfer and change positions slowly. Date Initiated: 06/03/2021."

The physician orders for Resident #383 documented in part, "xray of her left knee today one time only for trace left knee edema until 06/02/2021 23:59 (11:59 p.m.). Order Date: 06/02/2021."

The progress notes for Resident #383 documented in part, "6/2/2021 12:49 (12:49 p.m.) Note Text: CC (chief complaint): "I slid to the floor earlier this morning" HPI (history of present illness): Resident reports she was in the bathroom about 0400 (4:00 a.m.) with a walker and as she was leaving the bathroom, she said her left knee gave way nd [sic] she scooted herself to the floor. She stated she did not fall. She was adamant she did not fall. She also did not have footwear on. She was educated on having gripper socks on or shoes when ambulating. Her left knee is slightly swollen, but not much more than previously. She had had a ground level fall in her garage, resulting in a left hip fracture which underwent repair on 5/23. Her dressing is intact and is due to come off within 7-10 days, possible removal today. I will order x-ray of left knee to ensure no injury..."

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The clinical record failed to evidence any post fall documentation for the reported slip to the floor on 6/2/2021.

The clinical record failed to evidence documentation the responsible party was notified of the reported slip to the floor on 6/2/2021 or the physicians order for an x-ray of the resident's left knee.

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that they had updated Resident #383's care plan but did not remember the resident or any falls.

On 10/4/2021 at 2:50 p.m., an interview was conducted with LPN #12. LPN #12 stated that they worked the night shift (11:00 p.m.-7:00 a.m.) with Resident #383. LPN #12 stated that they remembered speaking to Resident #383's responsible party regarding a fall prior to them being moved and put on isolation on 5/27/2021 and that there should be a progress note about it.

On 10/5/2021 at 8:23 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated that they would review the clinical record and see if they were able to evidence documentation of notification of the responsible party regarding the reported slip to the floor on 6/2/2021.

On 10/5/2021 at 10:23 a.m., an interview was conducted with ASM #3, nurse practitioner. ASM #3 stated that they did not remember Resident #383 and were not sure if the staff or the resident

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reported the slip to the floor on 6/2/2021 to them. ASM #3 stated that they did not remember having any conversations with Resident #383's responsible party.

On 10/5/2021 at 12:19 p.m., ASM #2, the director of nursing stated that they were unable to locate any evidence of notification of the responsible party for the reported slip to the floor on 6/2/2021 and physician ordered x-ray.

On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM (administrative staff member) #2 for the facility policy on responsible party notification.

The facility policy, "Change in a Resident's Condition or Status" dated May 2017 documented in part, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status..."

On 10/5/2021 at approximately 1:15 p.m., ASM (administrative staff member) #2, the director of nursing was made aware of the above concern.

No further information was presented prior to exit.

Complaint Deficiency

References:

1. Femur fracture: a fracture (break) in the femur in leg. It is also called the thigh bone. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm.

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F 580	Continued From page 56 2. Major depressive disorder: is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.	F 580		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582	1. Resident #483 no longer resides in the center. Resident #132. 13 remain in center, due to nature of noncompliance unable to complete past events. 2. All residents whose services completed from 10/05/2021 to present received notification of ending of skilled services through Medicare accordingly. 3. DON or designee will educate all social service staff on required policy for notification of Responsible representative of termination of skilled services. 4. DON or designee will audit 10% of residents with ending of skilled services to ascertain receipt of advanced beneficiary notification event weekly times 4 weeks and monthly times 2 to ensure facility maintains proper notification. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined the facility staff failed to issue an advanced beneficiary notification for the ending of skilled services for three of three residents in the survey sample, (Residents #132, #13 and #483).

The facility staff failed to issue an advanced beneficiary notice upon discontinuing Medicare services for Resident #132 on 7/14/202, Resident #13 on 7/17/2021, and Resident #483 on 9/16/2021, thus not allowing the residents and/or their responsible party's to appeal the discharge from services decision.

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The findings include:

1. The facility staff failed to issue an advanced beneficiary notice to Resident #132 upon discontinuing Medicare services on 7/14/202, thus not allowing the resident and/or their responsible party to appeal the discharge from services decision.

Resident #132 was admitted to the facility on 5/25/2021 with diagnoses that included but were not limited to: depression, dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.)(1), and traumatic brain injury (happens when a bump, blow, jolt, or other head injury causes damage to the brain.) (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/7/2021, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance on one or more staff member for most of her activities of daily living.

The "Beneficiary Notice - Resident Discharged within the Last Six Months" form given to the administrator on entrance documented Resident #132 was discontinued off of Medicare A services on 7/14/2021.

Review of the clinical record revealed a physical medicine physician assistant's note dated

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F 582	Continued From page 59 7/12/2021, that documented, "Resident is at highest practical level of function. Agree with discharge from therapy services." Further review of the clinical record failed to evidence an "Advanced Beneficiary Notice" was given to the resident and/or their resident representative. An interview was conducted with OSM (other staff member) #4, the director of social services, on 10/5/2021 at 10:36 a.m. When asked about the process followed for issuing an advanced beneficiary notice for discharging a resident from Medicare services, OSM #4 stated the letter has to be issued 48 hours prior to discharge. OSM #4 stated she had just started and need to go through the files in her office to see if she can find the ones requested. OSM #4 stated her process is to have a binder with the letters and document where the resident went to; home, assisted living or stayed in the facility. After the resident or responsible party sign the letter it is scanned into (name of computer software system). OSM #4 stated she has started this process but the above discharge from services for Resident #132, was before her start date at the facility. OSM #4 stated she would further look for this notification in her office. OSM #4 returned on 10/5/2021 at 11:49 a.m. and stated she had looking in all of the piles in her office and cannot locate the letters on any of the residents that were requested, (Including Resident #132). ASM (administrative staff member) #2, the director of nursing, was made aware of the above concern on 10/5/2021 at 1:58 p.m. A request for a	F 582		

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policy related to the issuing of the advanced beneficiary notices was requested at this time.

On 10/5/2021 at 3:10 p.m. ASM #2 stated, via email, the facility did not have a policy related to the issuing of an advanced beneficiary notice.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.
(2) This information was obtained from the following website: https://medlineplus.gov/traumaticbraininjury.html.

2. The facility staff failed to issue an advanced beneficiary notice to Resident #13 upon discontinuing of Medicare services on 7/17/2021, thus not allowing the resident and/or their responsible party to appeal the discharge from services decision.

Resident #13 was admitted to the facility on 6/18/2021 with diagnoses that included but were not limited to: Bipolar disorder (a mental disorder characterized by episodes of mania and depression) (1), insomnia and history of colon cancer.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/24/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring limited assistance of one staff member for most of his activities of daily living.

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The "Beneficiary Notice - Resident Discharged within the Last Six Months" form given to the administrator on entrance documented Resident #13 was discontinued off of Medicare A services on 7/17/2021.

Review of the clinical record failed to evidence any documentation related to the discontinuing of Medicare services. Further review of the clinical record failed to evidence an "Advanced Beneficiary Notice" was given to the resident and/or their resident representative.

An interview was conducted with OSM (other staff member) #4, the director of social services, on 10/5/2021 at 10:36 a.m. When asked about the process followed for issuing an advanced beneficiary notice for discharging a resident from Medicare services, OSM #4 stated the letter has to be issued 48 hours prior to discharge. OSM #4 stated she had just started and need to go through the files in her office to see if she can find the ones requested. OSM #4 stated her process is to have a binder with the letters and document where the resident went to; home, assisted living or stayed in the facility. After the resident or responsible party sign the letter it is scanned into (name of computer software system). OSM #4 stated she has started this process but the above discharge from services for Resident #13, was before her start date at the facility. OSM #4 stated she would further look for this notification in her office.

OSM #4 returned on 10/5/2021 at 11:49 a.m. and stated she had looking in all of the piles in her office and cannot locate the letters on any of the residents that were requested, (including

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Resident #13).

ASM #2, the director of nursing, was made aware of the above concern on 10/5/2021 at 1:58 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.

3. The facility staff failed to issue an advanced beneficiary notice to Resident #483 upon discontinuing of Medicare services on 9/16/2021, thus not allowing the resident and/or their responsible party to appeal the discharge from services decision.

Resident #483 was admitted to the facility on 7/29/2021 with diagnoses that included but were not limited to: diabetes, high blood pressure and fracture of the lower leg.

The most recent MDS (minimum data set) assessment, a discharge assessment, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident is capable of making daily cognitive decisions. The resident was coded as requiring limited assistance of one staff member for most of her activities of daily living.

The "Beneficiary Notice - Resident Discharged within the Last Six Months" form given to the administrator on entrance documented Resident #483 was discontinued off of Medicare A services on 9/16/2021.

Review of the clinical record failed to evidence

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F 582	Continued From page 63 any documentation related to the discontinuing of Medicare services. Further review of the clinical record failed to evidence an "Advanced Beneficiary Notice" was given to the resident and/or their resident representative. An interview was conducted with OSM (other staff member) #4, the director of social services, on 10/5/2021 at 10:36 a.m. When asked about the process followed for issuing an advanced beneficiary notice for discharging a resident from Medicare services, OSM #4 stated the letter has to be issued 48 hours prior to discharge. OSM #4 stated she had just started and need to go through the files in her office to see if she can find the ones requested. OSM #4 stated her process is to have a binder with the letters and document where the resident went to; home, assisted living or stayed in the facility. After the resident or responsible party sign the letter it is scanned into (name of computer software system). OSM #4 stated she has started this process but the above discharge from services for Resident #483, was before her start date at the facility. OSM #4 stated she would further look for this notification in her office. OSM #4 returned on 10/5/2021 at 11:49 a.m. and stated she had looking in all of the piles in her office and cannot locate the letters on any of the residents that were requested, (including Resident #483). ASM #2, the director of nursing, was made aware of the above concern on 10/5/2021 at 1:58 p.m. No further information was provided prior to exit.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment	F 584	1. Resident #72 remains in the center and bed rail was cleaned immediately upon notification of visual inspection.	

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F 584	Continued From page 64 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	2. All resident rooms will be assessed to ensure environment is free of debris and maintained in a clean manner. 3. DON or designee will educate all housekeeping staff to ensure part of routine cleaning will include inspection of resident rooms to ensure free of substances and importance of infection control. 4. DON or designee will audit 10% of resident's rooms to ensure compliance with maintaining safe and clean environment weekly times 4 weeks and monthly times 2 to ensure facility maintains a clean and homelike environment. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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§483.10(i)(7) For the maintenance of comfortable sound levels.
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 maintain a clean, comfortable, homelike environment for one of 84 residents in the survey sample, Resident #72.

The facility staff failed to clean Resident #72's bed rail. On 9/28/21, 9/29/21 and 9/30/21, a brown substance was observed on the resident's left bed rail.

The findings include:

Resident #72 was admitted to the facility on 3/9/15. Resident #72's diagnoses included but were not limited to diabetes, dementia and osteoarthritis. Resident #72's significant change in status minimum data set assessment with an assessment reference date of 8/5/21, coded the resident's cognitive skills for daily decision making as moderately impaired.

On 9/28/21 at 12:17 p.m. and 9/29/21 at 10:41 a.m., Resident #72 was observed lying in bed. A brown substance (approximately one and a half inch in length by a half inch in width) was observed on the left bed rail.

On 9/30/21 at 8:49 a.m., an interview was conducted with OSM (other staff member) #3 (the director of housekeeping). OSM #3 stated bed rails should be cleaned daily. At this time, OSM #3 observed the brown substance on Resident

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F 584	Continued From page 66 #72's left bed rail. OSM #3 stated she did not know what the substance was but it looked like dried coffee or dried chocolate ice cream. OSM #3 stated the dirty bed rail was unacceptable and she would have it taken care of. On 10/4/21 at 11:25 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 policy titled, "Cleaning and Disinfecting Residents' Rooms" documented, "7. Clean personal use items (e.g. lights, phones, call bells, bedrails, etc.) with disinfectant solution at least twice weekly." No further information was presented prior to exit.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585	1. Resident #153 remains in the center, upon notification of auditors finding of reported grievance for missing memorial t-shirt; facility-initiated grievance with placement of item prior to auditors' completion of inspection. 2. Review of all grievances completed from 09/01/2021 to ensure follow-up and resolution of stated grievance. 3. DON or designee will educate all facility staff on the policy related to reporting to grievances and timely resolution.	

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F 585	Continued From page 67 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as	F 585	4.DON or designee will audit 10% of all grievances to ensure resolution and follow-up completed weekly times 4 weeks and monthly times 2 to ensure facility maintains proper notification. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance Committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 585	Continued From page 68 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff	F 585		

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failed to act upon and make prompt efforts to resolve a reported grievance for one of 84 residents in the survey sample, Resident #153.

The facility staff failed to evidence Resident #153's verbal grievance regarding a missing clothing item was promptly acted upon and efforts made to resolve the resident's grievance.

The findings include:

Resident #153 was admitted to the facility with diagnoses including but not limited to bipolar disorder (1) and diabetes (2). Resident #153's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 as scoring a 12 on the brief interview for mental status (BIMS) assessment, 12- being moderately impaired for making daily decisions.

On 9/28/2021 at approximately 3:37 p.m., an interview was conducted with Resident #153. Resident #153 stated that they had attended their sister's funeral in February of 2021 and had a memorial t-shirt with her sisters picture on it, which meant a lot to her that the facility had not returned from being washed. Resident #153 stated that they had reported the t-shirt missing to LPN (licensed practical nurse) #10, the unit nurse manager several times in late February and March but had never gotten a response from the facility other than they were looking for it.

The comprehensive care plan for Resident #153 documented in part, "PSYCHOTROPIC MEDICATIONS: [Name of Resident #153] is at risk for adverse effects related to use of anti-depression medication, use of

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antianxiety/anxiolytic medication, use of antipsychotic medication. Diagnosis of Bipolar disorder and treatment resistant depression. Recently younger sister suddenly died. Date Initiated: 02/11/2021, Revision on: 09/27/2021."

The progress notes for Resident #153 documented in part, "2/26/2021 19:05 (7:05 p.m.) Note Text: F/U (follow up) LOA (leave of absence) to funeral COVID-19 (3) screening..."

Review of the facility grievances dated 1/1/2021 through the present failed to evidence any grievances regarding missing clothing for Resident #153.

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN #10, the unit nurse manager. LPN #10 stated that when residents reported missing items they filled out a concern form, searched the resident's room, and notified the laundry to search for the item. LPN #10 stated that if the item was not found they notified social services or administration to reimburse the resident if possible. LPN #10 stated that there wasn't a set timeframe for grievance resolution that they knew of. LPN #10 stated that normally the resident was asked to provide a receipt or they came to a compromise for the missing item. LPN #10 stated that they were aware of Resident #153's missing t-shirt with her sister's photo on it. LPN #10 stated that they could not put a value on the shirt and they had searched for it and were unable to locate it. LPN #10 stated that they had turned the missing shirt over to the former social worker to resolve the grievance after they had searched for it and was not sure of the resolution.

On 10/5/2021 at approximately 9:15 a.m., a

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request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on grievance resolution.

The facility policy "Grievances/Complaints, Filing" dated April 2017 documented in part, "Residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances (e.g., the State Ombudsman). The Administrator and staff will make prompt efforts to resolve grievances to the satisfaction of the resident and/or representative...All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response...Upon receipt of a grievance and/or complaint, the Grievance Officer will review and investigate the allegations and submit a written report of such findings to the Administrator within five (5) working days of receiving the grievance and/or complaint...The results of all grievances files, investigated and reported will be maintained on file for a minimum of three years from the issuance of the grievance decision..."

On 10/4/2021 at approximately 4:30 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was presented prior to exit.

References:

1. Bipolar disorder: (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in

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F 585	Continued From page 72 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. 2. Diabetes mellitus: A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 3. COVID-19 is caused by a coronavirus called SARS-CoV-2. Coronaviruses are a large family of viruses that are common in people and may different species of animals, including camels, cattle, cats, and bats. Rarely, animal coronaviruses can infect people and then spread between people. This occurred with MERS-CoV and SARS-CoV, and now with the virus that causes COVID-19. The SARS-CoV-2 virus is a betacoronavirus, like MERS-CoV and SARS-CoV. All three of these viruses have their origins in bats. The sequences from U.S. patients are similar to the one that China initially posted, suggesting a likely single, recent emergence of this virus from an animal reservoir. However, the exact source of this virus is unknown. This information was obtained from the website: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#How-COVID-19-Spreads	F 585		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F 604	1. Resident #502 no longer resides in the facility. 2. All residents are at risk and will be evaluated for use of physical restraint.	

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F 604	Continued From page 73 §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to prevent a resident from being physically restrained for one of 84 residents in the survey sample, Resident #502. On 5/6/21, Resident #502 was discovered lying in bed, with her left wrist tied to the bed rail. The findings include:	F 604	3. DON or designee will educate all facility nursing staff on centers policy for restraint use. 4. DON or designee will audit 10% of residents to ascertain free from physical restraint weekly times 4 weeks and monthly times 2 to ensure facility staff maintain a respectful and dignified environment, free of unnecessary restraint. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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Resident #502 was admitted to the facility on 4/27/16, and most recently readmitted on 12/9/20, with diagnoses including dementia with behaviors and arthritis. She was discharged from the facility on 6/12/21. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/21, the resident was coded as being severely cognitively impaired for making daily decisions, having scored one out of 15 on the BIMS (brief interview for mental status). She was coded as not being placed in physical restraints during the look back period.

A review of Resident #502's clinical record revealed the following progress note, dated 5/6/21: "[Resident #502] was observed with wristband attached to the arm rail of her bed via article of clothing. The wristband was removed and a skin assessment was completed. No integrity issues noted."

A review of Resident #502's comprehensive care plan dated 5/11/16 and updated 6/26/16 revealed, in part: "At risk for changes in mood related to diagnosis of dementia, atypical psychosis ...Assess for physical/environmental changes that may precipitate change in mood." The review revealed no update regarding the resident being placed in physical restraints.

A review of the final FRI (facility reported incident) submitted by the facility to the state agency on 5/11/21 revealed, in part: "On [5/6/21], staff observed [Resident #502]'s wristband was attached to the bedrail via a string-like material. Investigation findings: [Resident #502] noted to be without injury. All residents on unit interviewed

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to ascertain feelings of safety, all reported no area of concern. All residents on unit assessed for signs of injury, non-observed. Psychosocial well-being will continue to be followed up on by Social Worker. Care Plan reviewed and revised to reflect appropriate care...This allegation is substantiated however investigation remains ongoing."

On 9/30/21 at 10:27 a.m., ASM (administrative staff member) #4, the medical director, was interviewed. He stated he knew Resident #502 for many years. ASM #4 stated he was not familiar with the circumstances regarding Resident #502's being tied to her bed, but he believed a nurse and perhaps a supervisor were terminated as a result.

On 9/30/21 at 11:47 a.m., CNA (certified nursing assistant) #8 was interviewed. She stated she was in the rotation of CNAs who took care of Resident #502. CNA #8 stated on 5/6/21, she went into the resident's room in preparation for bathing her. She stated she saw the resident's left arm at the wrist tied to the bed rail. She stated a thin black piece of material was wrapped around her wrist, and tied to the bed. She stated she immediately notified the nurse, who notified upper management. CNA #8 stated Resident #502 did not demonstrate any signs of injury.

On 9/30/21 at 12:06 p.m., LPN (licensed practical nurse) #7, a unit manager, was interviewed. She stated on 5/6/21, a CNA went to her and reported that Resident #502 was tied to her bedrail. LPN #7 stated she assessed the resident for imminent danger, and after consulting with ASM (administrative staff member) #2, the director of nursing, she then removed the wrist restraint. She stated the piece of material tying the resident to

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the bed rail looked a drawstring from a pair of sweatpants. LPN #7 stated Resident #502's left wrist was "a little red," but her assessment revealed the resident was not experiencing any pain. She stated she called the resident's family to let them know what had happened.

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked if the facility ever determined who had restrained Resident #502 on 5/6/21, she stated they had not. ASM #2 stated both the overnight nurse and CNA were temporary agency staff, and had not been allowed to return to the building. ASM #2 stated the licensing board for the nurse and CNA had been in the facility within the last few weeks to investigate this incident, but the facility had not received the results.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns.

A review of the facility policy, "Use of Restraints," revealed, in part: "Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully.
Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff conven-ience, or for the prevention of falls.
When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented...5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another

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	495227	A. BUILDING ______ B. WING ______	C 10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

(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 604	Continued From page 77 less restrictive intervention AND a restraint is required to: Treat the medical symptom; Protect the resident ' s safety; and Help the resident attain the highest level of his/her physical or psychological well-being." No further information was provided prior to exit. Complaint Deficiency	F 604		
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 resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after	F 622	1. Resident #111 and #72 remain in the center. Due to the nature of requested evidence facility is not able to rectify on past event. 2. All residents discharged to hospital reviewed to ascertain physician documentation indicates need for transfer to hospital and all supporting documentation accompanies resident to receiving facility. 3. DON or designee will educate all facility nursing staff on the documentation required at time of transfer to include, comprehensive care plan goals, advance directives, special care instructions, resident representative information and discharge summary. Physicians will receive education to ensure provider documentation indicate necessity of transfer. 4. DON or designee will audit 10% of all residents transferred to hospital to ensure compliance of mandatory documentation from provider and continuity of care documentation was completed weekly times 4 weeks and monthly times 2 to ensure facility indicates reason necessary for transfer and supporting paperwork is transferred to maintain continuum of care. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 622	Continued From page 78	F 622		

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 discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and

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F 622	Continued From page 79	F 622		

Continued From page 79

(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 documented evidence of facility-initiated transfer requirements for two of 84 residents in the survey sample, Residents #111 and #72.

1.a. Resident #111 was transferred to the hospital on 8/30/21. The physician failed to document the basis for the transfer, the specific resident needs that could not be met, facility attempts to meet the resident needs and the service available at the receiving facility to meet the resident's needs.

1.b. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #111 was transferred to the hospital on 9/6/21.

F 622 Continued From page 80 F 622

2. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #72 was transferred to the hospital on 7/18/21.

The findings include:

1.a. Resident #111 was admitted to the facility on 5/24/21. Resident #111's diagnoses included but were not limited to diabetes, dementia and anxiety disorder. Resident #111's quarterly minimum data set assessment with an assessment reference date of 8/28/21, coded the resident's cognition as severely impaired.

Review of Resident #111's clinical record revealed a nurse's note dated 8/30/21, that documented Resident #111 was transferred to the hospital due to aggressive behaviors and a fall. Further review of Resident #111's clinical record failed to reveal physician documentation regarding the basis for the transfer, the specific resident needs that could not be met, facility attempts to meet the resident needs and the service available at the receiving facility to meet the needs of Resident #111.

On 9/30/21 at 10:27 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 was asked if the facility physicians document why a resident is transferred to the hospital and why facility staff cannot care for the resident. LPN #7 stated, "In my experience, yes. The providers that do are (name of one physician and name of one nurse practitioner). LPN #7 did not name Resident #111's physician.

On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2

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F 622	Continued From page 81	F 622		

(the director of nursing) were made aware of the above concern.

The facility policy titled, "Attending Physician Responsibilities" documented, "Supporting Resident Discharges and Transfers...3. The Attending Physician will provide a summary of pertinent medical discharge information within 30 days of discharge or transfer of a resident."

No further information was presented prior to exit.

1.b. Review of Resident #111's clinical record revealed a nurse's note dated 9/6/21 that documented the resident was transferred to the hospital due to a fall. Further review of Resident #111's clinical record failed to reveal documentation to evidence that all required information, including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals, was provided to the receiving hospital staff.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated a face sheet, bed hold policy, advance directive, code status, SBAR (Situation-Background-Assessment-Recommendation) form, history and physical, physician orders, the most recent progress note, transfer notice, a copy of the care plan goals and transfer form should be sent to hospital staff when a resident is transferred to the hospital. LPN #7 stated this is evidenced by a nurse's note.

On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2

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F 622	Continued From page 82	F 622		

(the director of nursing) were made aware of the above concern.

The facility policy titled, "Transfer or Discharge, Emergency" documented, "4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures:
a. Notify the resident's Attending Physician;
b. Notify the receiving facility that the transfer is being made;
c. Prepare the resident for transfer;
d. Prepare a transfer form to send with the resident;
e. Notify the representative (sponsor) or other family member;
f. Assist in obtaining transportation; and
g. Others as appropriate or as necessary."

No further information was presented prior to exit.

2. Resident #72 was admitted to the facility on 3/9/15. Resident #72's diagnoses included but were not limited to diabetes, dementia and osteoarthritis. Resident #72's significant change in status minimum data set assessment with an assessment reference date of 8/5/21, coded the resident's cognitive skills for daily decision making as moderately impaired.

Review of Resident #72's clinical record revealed a nurse's note dated 7/18/21 that documented the resident was transferred to the hospital due to a right hip dislocation. Further review of Resident #72's clinical record failed to reveal documentation to evidence that all required information, including physician contact information, resident representative contact

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F 622	Continued From page 83 information, special instructions for ongoing care, advance directives and comprehensive care plan goals, was provided to the hospital staff. On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated a face sheet, bed hold policy, advance directive, code status, SBAR (Situation-Background-Assessment-Recommend ation) form, history and physical, physician orders, the most recent progress note, transfer notice, a copy of the care plan goals and transfer form should be sent to hospital staff when a resident is transferred to the hospital. LPN #7 stated this is evidenced by a nurse's note. On 10/4/21 at 11:25 a.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;	F 623	1. Residents #111, #19 and #72 remain in the center. Due to the nature of requested evidence facility is not able to establish on past event. 2. All residents discharged/transferred to hospital reviewed to ensure proof of proper documentation of written notification to RR and ombudsman of all transfers since 10/05/2021. 3. DON or designee will educate all facility admission and discharge planning staff on requirements for providing written notification to RR and ombudsman of transfers to hospital with proof maintained in facility records.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 623	Continued From page 84 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 (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	F 623	4. DON or designee will audit 10% of all residents transferred to hospital to ensure compliance of mandatory documentation and written notification to RR and ombudsman of transfer was completed weekly times 4 weeks and monthly times 2 to ensure facility maintains proper notification. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/5/21

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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;
(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

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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 provide written notice of transfer to a RR (resident representative) and/or the ombudsman for three of 84 residents in the survey sample, Residents #111, #72 and #19.

1. Resident #111 was transferred to the hospital on 8/30/21 and on 9/6/21. A. The facility staff failed to provide written notification of the transfer to the resident's representative and the ombudsman for the 8/30/21 transfer, and B. failed to provide written notification of the transfer to the resident's representative for the 9/6/21 transfer.

2. Resident #72 was transferred to the hospital on 7/18/21. The facility staff failed to provide written notification of the transfer to the resident's representative.

3. Resident #19 was transferred to the hospital on 7/31/21. The facility staff failed to provide written notification of the transfer to the ombudsman

The findings include:

1. A. Resident #111 was admitted to the facility on 5/24/21. Resident #111's diagnoses included but were not limited to diabetes, dementia and anxiety disorder. Resident #111's quarterly minimum data set assessment with an assessment reference date of 8/28/21, coded the resident's cognition as severely impaired.

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Review of Resident #111's clinical record revealed a nurse's note dated 8/30/21 that documented Resident #111 was transferred to the hospital due to aggressive behaviors and a fall. Further review of the resident's clinical record (including nurses' notes) failed to reveal written notification of the transfer was provided to Resident #111's representative and the ombudsman. Review of a facility fax to the ombudsman, dated 9/1/21, titled, "Aug 2021 Discharges" failed to reveal documentation of Resident #111's transfer to the hospital on 8/30/21, on the list.

On 9/30/21 at 8:59 a.m., an interview was conducted with OSM (other staff member) #4, the social services director who began employment at the facility during the week of survey. OSM #4 stated written notification of resident transfers to the ombudsman is required monthly and is faxed. In regards to written notification of resident transfers to resident representatives, OSM #4 stated the nurses are supposed to send a transfer notice form.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated nurses are supposed to provide written notification of transfer to resident representatives via a transfer notice form.

Further review of Resident #111's clinical record failed to reveal a transfer notice form for the residents transfer to the hospital on 8/30/21.

On 10/4/21 at 11:25 a.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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The facility policy titled, "Transfer or Discharge, Emergency" documented, "4. Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures:
a. Notify the resident's Attending Physician;
b. Notify the receiving facility that the transfer is being made;
c. Prepare the resident for transfer;
d. Prepare a transfer form to send with the resident;
e. Notify the representative (sponsor) or other family member;
f. Assist in obtaining transportation; and
g. Others as appropriate or as necessary." The policy did not document information regarding written notification of transfer to resident representatives or the ombudsman.

No further information was presented prior to exit.

1. B. Review of Resident #111's clinical record revealed a nurse's note dated 9/6/21 that documented the resident was transferred to the hospital due to a fall. Further review of the resident's clinical record, including nurses' notes, failed to reveal written notification of the transfer was provided to Resident #111's representative.

On 9/30/21 at 8:59 a.m., an interview was conducted with OSM (other staff member) #4, the social services director. OSM #4 stated the nurses are supposed to send a transfer notice form.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7.

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LPN #7 stated nurses are supposed to provide written notification of transfer to resident representatives via a transfer notice form.

Further review of Resident #111's clinical record failed to reveal a transfer notice form for Resident #11's transfer to the hospital on 9/6/2021.

On 10/4/21 at 11:25 a.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.

2. Resident #72 was admitted to the facility on 3/9/15. Resident #72's diagnoses included but were not limited to diabetes, dementia and osteoarthritis. Resident #72's significant change in status minimum data set assessment with an assessment reference date of 8/5/21, coded the resident's cognitive skills for daily decision making as moderately impaired.

Review of Resident #72's clinical record revealed a nurse's note dated 7/18/21 that documented the resident was transferred to the hospital due to a right hip dislocation. Further review of the resident's clinical record, including nurses' notes, failed to reveal written notification of the transfer was provided to Resident #72's representative.

On 9/30/21 at 8:59 a.m., an interview was conducted with OSM (other staff member) #4 (the social services director). OSM #4 stated the nurses are supposed to send a transfer notice form.

On 9/30/21 at 10:37 a.m., an interview was

F 623

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F 623	Continued From page 90 conducted with LPN (licensed practical nurse) #7. LPN #7 stated nurses are supposed to provide written notification of transfer to resident representatives via a transfer notice form. Further review of Resident #72's clinical record failed to reveal a transfer notice form for Resident #72. On 10/4/21 at 11:25 a.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. 3. Resident #19 was admitted to the facility on 4/10/17. Resident #19's diagnoses included but were not limited to muscle weakness, repeated falls and high blood pressure. Resident #19's quarterly minimum data set assessment with an assessment reference date of 7/8/21, coded the resident's cognition as severely impaired. Review of Resident #19's clinical record revealed the resident was transferred to the hospital on 7/31/21 due to a fall. Further review of the resident's clinical record, including nurses' notes, failed to reveal written notification of the transfer was provided to the ombudsman. Review of a facility fax to the ombudsman, dated 8/14/21 and titled, "July 2021 Discharges" failed to reveal documentation of Resident #19's 7/31/21, transfer on the list. On 9/30/21 at 8:59 a.m., an interview was conducted with OSM (other staff member) #4, the social services director who began employment at the facility during the week of survey. OSM #4	F 623		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 91 stated written notification of resident transfers to the ombudsman is required monthly and is faxed. On 10/4/21 at 11:25 a.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 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to complete a significant change MDS (minimum data set) assessment for one of 84 residents in the survey sample, Resident #47. The facility staff failed to complete a significant change MDS assessment after dialysis services for the resident were discontinued due to improved laboratory values on 9/6/21.	F 637	1. Resident #47 remains in the center, upon notification from auditor, significant change of condition assessment was completed during duration of survey. 2. All residents reviewed from 09/01/2021 to ensure completion of significant change of condition assessment was completed when appropriate change was observed. 3. DON or designee will educate all MDS coordinators on policy regarding completion of significant change of condition assessment upon significant improvement or decline of resident.	

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F 637	Continued From page 92 The findings include: Resident #47 was admitted to the facility on 7/19/21 with the diagnoses of but not limited to metabolic encephalopathy, chronic obstructive pulmonary disease, congestive heart failure, atrial fibrillation, somatoform disorder, angina, depression, insomnia, high blood pressure, end stage renal disease, and dysphagia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/22/21. The resident was coded as being cognitively impaired in ability to make daily life decisions. Resident #47 was coded as requiring extensive assistance for transfers and limited assistance for all other areas of activities of daily living. Resident #47 was coded as receiving dialysis services. A review of the clinical record revealed a nurse's note dated 9/6/21 that documented, "Resident is alert and verbal, dialysis called this AM, writer was advised that resident does not need dialysis due to better labs [laboratory tests] results. Daughter (name) and MD (medical doctor) aware." Further review of the clinical record revealed a physician's progress note dated 9/17/21 that documented, "The hemodialysis catheter will be removed today." As of the survey date of 10/4/21, there was no evidence of a significant change MDS (minimum data set) assessment being completed. On 10/4/21 at 3:00 PM in an interview with RN #2 (Registered Nurse) the MDS nurse, RN #2 stated,	F 637	4. DON or designee will audit 10% of all residents to ascertain if significant change of condition identified and completion of required MDS assessment was completed weekly times 4 weeks and monthly times 2 to ensure facility completes significant change of condition assessments in accordance with recommendations. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 637	Continued From page 93	F 637		

"If a significant change is identified, a significant change MDS is completed within 14 days. Stopping dialysis is a significant change and an assessment should have been done." When asked what policy is followed to complete the MDS, she stated, "The RAI (Resident Assessment Instrument) Manual."

According to the RAI Manual, October 2019, Version 1.17.1, Page 2-22 documented:

"A "significant change" is a major decline or improvement in a resident's status that:
1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan."

Page 2-23 documented:

"An SCSA is appropriate when:
- There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments..."

On 10/4/21 at 5:00 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, was made aware of the findings. No further information was provided by the end of the survey.

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F 645	Continued From page 94	F 645		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide	F 645	1. Resident #160 no longer resides in facility. Resident #22 remains in center. Facility is working with referral source to locate PASAAR. 2. Review all current residents to ensure completion of PASAAR and remains on medical record. 3. DON or designee will provide facility social worker and admissions on policy for receiving PASAARS as appropriate. 4. DON or designee will audit 10% of all new admissions to ensure PASAAR included on in medical records for all appropriate instance's weekly times 4 weeks and monthly times 2 to ensure that the facility maintains requirements for preadmission screening. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 645	Continued From page 95	F 645		

for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to ensure a preadmission screening and resident review, (PASARR) was completed and or completed accurately for two of 84 residents in the survey sample, Resident #160 and Resident #22.

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1. The facility failed to ensure a PASARR was completed upon admission for Resident #160.

2. The facility staff failed to thoroughly complete Resident #22's level I PASRR (Preadmission Screening and Resident Review) and failed to refer the resident for a level II PASRR as recommended.

The findings include:

1. Resident #160 was admitted to the facility on 9/9/21. Resident #160's diagnoses included but were not limited to: end stage renal disease (end stage of renal failure-inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance) (1) and schizophrenia (mental disorder characterized by gross distortions of reality, withdrawal from social contacts and disturbances of thought, language, perception and emotional response) (2) and chronic obstructive pulmonary disease 'COPD' (chronic and non-reversible lung disease) (3).

Resident #160's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/6/20, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded the resident as requiring extensive assistance in bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene and bathing; supervision with eating.

A review of Resident #160's clinical record failed to evidence the completion of a PASAAR either

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prior to or on admission to the facility on 9/9/21.

An interview was conducted on 9/29/21 at 3:40 PM, with ASM (administrative staff member) #2, the director of nursing. When asked if there was a PASARR completed for Resident #160, ASM #2 stated, "No, we don't have one."

An interview was conducted on 10/05/21 at 9:23 AM, with OSM (other staff member) #4, the director of social services. When asked the purpose of the PASARR, OSM #4 stated, "The PASARR is used to determine mental illness or disability so we can determine if we can meet their (a residents) needs at this facility." When asked who is responsible to obtain the PASARR, OSM #4 stated, "Usually we get a PASARR prior to coming into the facility or at the time of admission. Normally social services would do this on admission. OSM #4 stated, "I started three weeks ago. I was not here when this resident (Resident #160) was admitted on 9/9/21. The Social worker ensures that level II screening is done and being reported."

The facility policy, "Admission Criteria", dated 3/19, documented in part, "All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR). The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for MD, ID or RD. If the Level I screen indicates that the individual may meet the criteria for a MD, ID or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and

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F 645	Continued From page 98 determination) screening process." On 10/4/21 at 4:50 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above findings. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 498. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 518. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. 2. The facility staff failed to thoroughly complete Resident #22's level I PASRR (Preadmission Screening and Resident Review) and failed to refer the resident for a level II PASRR as recommended. Resident #22 was admitted to the facility on 7/5/21. Resident #22's diagnoses included but were not limited to multiple sclerosis (1), seizures and major depressive disorder. Resident #22's quarterly minimum data set assessment with an assessment reference date of 9/24/21, coded the resident's cognition as severely impaired. Review of Resident #22's clinical record revealed a DMAS (Department Of Medicaid Assistance Services) - 95 form titled, "SCREENING FOR MENTAL ILLNESS, MENTAL RETARDATION/INTELLECTUAL DISABILITY, OR RELATED CONDITIONS" and dated 7/5/21. The form documented, "1. DOES THE	F 645		

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INDIVIDUAL MEET NURSING FACILITY CRITERIA?" A blank check box was documented beside "Yes" and "No." Neither option was checked. The form further documented, "Can a safe and appropriate plan of care be developed to meet all services and supports including medical/nursing/custodial care needs?" A blank check box was documented beside "Yes" and "No." Neither option was checked.

The form further documented, "3. DOES THE INDIVIDUAL HAVE A DIAGNOSIS OF INTELLECTUAL DISABILITY (ID) WHICH WAS MANIFESTED BEFORE AGE 18?" A blank check box was documented beside "Yes" and "No." Neither option was checked. The form further documented, "4. DOES THE INDIVIDUAL HAVE A RELATED CONDITION? Yes. a. Is the condition attributable to any other condition (e.g. multiple sclerosis...) other than MI (mental illness), found to be closely related to IDD (intellectual/developmental disability) because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of IDD persons and requires treatment of services similar to those of these persons? Yes. b. Has the condition manifested before age 22? Yes. c. Is the condition likely to continue indefinitely? Yes. d. Has the condition resulted in substantial limitations in 3 or more of the following areas of major life activity; self-care understanding and use of language, learning, mobility, self-direction, and capacity for independent living? Yes. 5. RECOMMENDATION a. (a check mark beside) IDD or Related Condition (#3 or #4 is checked 'Yes')."

The instructions for completing the DMAS-95 form documented, "1. Nursing Facility Level of

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F 645	Continued From page 100 Care: Indicate whether the individual meets nursing facility level of care criteria. For reference, level of care criteria can be found in the Medicaid Long-Term Services and Supports Manual Chapter IV found on the Virginia Medicaid portal. If 'yes' is checked, complete the screening. If 'no', is checked, the individual does NOT meet nursing facility level of care criteria, do not complete the Level I screening and do not refer for a Level II evaluation... 3. Determination of Intellectual Disability ID: Check 'yes' if the individual has a level of intellectual disability (mild, moderate, severe, or profound) described in the Classification in Mental Retardation: Chapter 3. American Association on Mental Deficiency (AAMD), 1983 that was manifested before age 18. Please note this reference is specifically cited in the Code of Federal Regulations but the AAMD is now known as the American Association on Intellectual and Developmental Disabilities (AAIDD) and the term Mental Retardation is no longer standardly used and has been replaced with Intellectual Disability. 4. Determination of Related Conditions: Check 'yes' for answer for 4, only if each item in 4, a-d is checked 'yes'. If any answer to a-d is 'no', then 'no' is checked for the overall question and do not refer for Level II evaluation for related conditions. a. Check 'yes' if the condition is attributable to any other condition, other than MI, found to be closely related to intellectual disability because this condition may result in impairment of general intellectual functioning or adaptive behavior similar to that of persons living with ID and requires treatment or services similar to those for persons living with ID. b. Check 'yes' if the condition has manifested before age 22	F 645		

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c. Cheek 'yes' if the condition is likely to continue indefinitely
d. Check 'yes' if the condition has resulted in substantial limitations in three (3) or more of the following areas of major life activity: self-care, understanding, use of language, learning, mobility, self-direction, and capacity for independent living. Circle the applicable areas."

The Pre-Admission Screening (PAS) Virginia Medicaid Web Portal Frequently Asked Questions website documented,
"Do I need to complete this form for a member I'm referring for Level I services?
Based upon the outcome of the Level I screening for MI/ID/RC, the completion of the DMAS-95 MI/MR Supplement will be determined. If the member is identified has having a mental illness, intellectual disability, or related condition during the Level I screening process, a referral for the completion of the Level II screening must be made. "This information was obtained from the website:
https://www.ecm.virginiamedicaid.dmas.virginia.gov/WorkplaceXT/getContent?impersonate=true&id={974BDA7E-F058-4675-BD19-9233DEB7E4B0}
&vsId={09D26C54-4895-4389-A19E-2ED4DD395861}
&objectType=document&objectStoreName=VAPRODOS1

The employee who completed Resident #22's DMAS-95 form (PASRR) was no longer employed at the facility.

On 9/30/21 at 8:59 a.m., an interview was conducted with OSM (other staff member) #4, the social services director. OSM #4 stated she

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completes a PASRR upon admission for every resident who is admitted to the facility. Resident #22's DMAS-95 form was reviewed with OSM #4. OSM #4 stated "yes" or "no" should have been checked for question #1. In regards to question #3, OSM #4 stated, "It's never okay to leave anything blank. If I would have done it, I would not have left anything blank. A lot of people don't get training on PASRR." In regards to the recommendation in question #5, OSM #4 stated Resident #22 should have been referred to the company that completes level II PASRRs. OSM #4 stated it sometimes takes a while for the company to respond and she would check to see if a referral for Resident #22 had been made.

On 9/30/21 at 12:52 p.m., OSM #4 stated she was unable to locate any paperwork to evidence Resident #22 had been referred for a level II PASRR.

On 10/4/21 at 11:25 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 policy titled, "Admission Criteria" documented, "9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process.
a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD.
b. If the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or

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she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.
(1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD.
(2) The social worker is responsible for making referrals to the appropriate state-designated authority.
c. Upon completion of the Level II evaluation, the State PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.
d. The State PASARR representative provides a copy of the report to the facility.
e. The interdisciplinary team determines whether the facility is capable of meeting the needs and services of the potential resident that are outlined in the evaluation.
f. Once a decision is made, the State PASARR representative, the potential resident and his or her representative are notified."

No further information was presented prior to exit.

Reference:

(1) "Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells." 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=ms&_ga=2.53710894.747995928.1633538618-221748656.1633538618

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	1. Resident #160 no longer resides in the center. Resident #22, #45, #82, #153, #145 and #165 care plans have been updated to represent comprehensive plan of care. 2. Ensure all current residents residing in center reviewed to ensure comprehensive care plan is established and implemented. 3. DON or designee will educate all facility nursing staff to ensure understanding and requirements for implementation of comprehensive care plans. 4. DON or designee will audit 10% of all residents to ascertain development and implementation of comprehensive care plan weekly times 4 weeks and monthly times 2 to ensure facility maintains the development/Implementation of comprehensive care plans. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5 Date of compliance will be	11/19/21

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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 staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to develop and/or implement the comprehensive care plan for seven of 84 residents in the survey sample, Resident #'s #160, #45, #82, #153, #145, #165 and #22.

The facility staff failed to develop a comprehensive care plan to address dialysis for Resident #160 and Resident #45; failed to develop a comprehensive care plan to address the physician prescribed use of an incentive spirometer for Resident #165, and failed to implement comprehensive care plan for obtaining and monitoring weights for Resident #82 and Resident #153; failed to implement the comprehensive care plan to provide treatments as ordered to Resident #153's and Resident #22's pressure ulcers and failed to implement the comprehensive care plan to provide oxygen as ordered by the physician to Resident #145.

The findings include:

1. Resident #160 was admitted to the facility on 9/9/21. Resident #160's diagnoses included but were not limited to: end stage renal disease 'ESRD' (end stage of renal failure-inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance) (1) and schizophrenia (mental disorder characterized by gross distortions of reality, withdrawal from social

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contacts and disturbances of thought, language, perception and emotional response) (2) and chronic obstructive pulmonary disease 'COPD' (chronic and non-reversible lung disease) (3).

Resident #160's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/6/20, coded the resident as scoring 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded Resident #160 as requiring extensive assistance in bed mobility, transfers, walking, locomotion, dressing, toilet use, personal hygiene and bathing; supervision with eating. MDS- Section H-Bowel and Bladder: coded the resident as frequently incontinent for both bowel and bladder. MDS-Section O-Special Treatments and Procedures: coded Resident #160 as receiving dialysis-yes.

A review of Resident #160's comprehensive care plan dated 9/12/21, failed to evidence dialysis as part of the care plan.

A review of the physician orders, dated 9/9/21, documented in part, "Hemodialysis Diagnosis: ESRD Dialysis Days and Time: M-W-F Pick up time: 10am Chair time: 10:55."

An interview was conducted on 9/30/21 at 10:00 AM with LPN (licensed practical nurse) #5, regarding the purpose of the comprehensive care plan. LPN #5 stated, "To identify the needs of the resident for all staff to see." When asked if dialysis services should be included in the comprehensive care plan, LPN #5 stated, "Yes, dialysis is on there and should include checking

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the dialysis site for signs of bleeding or infection."

An interview was conducted on 10/4/21 at 12:20 PM with LPN #2, the unit manager, regarding the purpose of the comprehensive care plan. LPN #2 stated, "It is for everyone to be on the same page and to know their needs. It is everything we need to do for the resident." When asked if dialysis should be on the comprehensive care plan, LPN #2 stated, "Yes, it should be on the care plan."

On 10/4/21 at 4:50 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

A review of the facility's "Care Planning-Interdisciplinary Team" policy, documented in part, "The care plan is based on the resident's comprehensive assessment and is developed by the care planning/interdisciplinary team including registered nurse and nursing assistants responsible for the resident's care."

A review of the facility's "End-Stage Renal Disease, Care of a Resident with" policy dated 9/10, documented in part, "The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 498.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 518.

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(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120.

2. The facility staff failed to develop a comprehensive care plan to address dialysis for Resident #45.

Resident #45 was admitted to the facility with diagnoses that included but were not limited to stage 4 kidney disease (1) and heart failure (2). Resident #45's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/20/2021, coded Resident #45 as scoring a 3 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 3- being severely impaired for making daily decisions. Section O coded Resident #45 as receiving dialysis while a resident at the facility.

The comprehensive care plan for Resident #45 failed to evidence a care plan related to or addressing dialysis services.

The physician order's for Resident #45 documented in part, "Hemodialysis (3) Diagnosis: ESRD (end stage renal disease) Dialysis Days and Time: Tues-Thurs-Sat Pick up time: varies Chair time: 11 am Dialysis Center: [Name and phone number of dialysis center] Transport Company: thru [Name and phone number of transport]. Order Date: 5/7/2021."

The progress notes for Resident #45 documented in part, "5/8/2021 13:13 (1:13 p.m.) ...Acute on Chronic Stage IV Kidney Disease- now on HD (hemodialysis)..."

On 10/4/2021 at 11:36 a.m., an interview was

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conducted with LPN (licensed practical nurse) #8. LPN #8 stated that care plans were a team effort. LPN #8 stated that the nurse manager was responsible for the baseline care plan and the MDS (minimum data set) nurse completed the comprehensive care plan which the nurses could update. LPN #8 stated that all dialysis residents should have a care plan addressing dialysis.

On 10/4/2021 at 2:15 p.m., an interview was conducted with RN (registered nurse) #2, MDS (minimum data set) nurse. RN #2 stated that the purpose of the care plan was to direct the care of the individual patient. RN #2 stated that the care plans were created by the interdisciplinary team and that they reviewed the CAAS (care area assessment summary) from the MDS assessment to direct the care plans they put into place. RN #2 stated that dialysis residents should have a care plan addressing their dialysis and the nurse manager would be responsible for creating it.

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN #10, the unit nurse manager. LPN #10 stated that the care plan was a communication tool for the staff to communicate the needs of the residents. LPN #10 stated that the care plan notified the CNA's (certified nursing assistants) of any special needs of the resident. LPN #10 stated that Resident #45 received dialysis and should have a dialysis care plan on their record. LPN #10 stated that they would review the care plan to see if there was a care plan to address dialysis.

On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility

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policy on care planning. ASM #2 also stated that the facility used Lippincott as their nursing standard of practice.

The facility policy "Care Planning- Interdisciplinary Team" documented in part, "...The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team..."

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..."

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. Kidney failure (ESRD): Healthy kidneys clean your blood by removing excess fluid, minerals, and wastes. They also make hormones that keep your bones strong and your blood healthy. But if the kidneys are damaged, they don't work properly. Harmful wastes can build up in your body. Your blood pressure may rise. Your body may retain excess fluid and not make enough red blood cells. This is called kidney failure. This

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information was obtained from the website: https://medlineplus.gov/kidneyfailure.html

2. Heart failure: A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm.

3. Hemodialysis: Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.

3. The facility staff failed to implement Resident #82's comprehensive care plan for obtaining and monitoring weights.

Resident #82 was admitted to the facility with diagnoses that included but were not limited to hemiplegia (1) and cerebral infarction (2). Resident #82's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/11/2021, coded Resident #82 as scoring a 2 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 2- being severely impaired for making daily decisions. Section K coded Resident #82 as receiving tube feeding and a therapeutic diet while a resident at the facility.

The comprehensive care plan for Resident #82

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documented in part, "At potential for nutritional risk r/t (related to) poor po (by mouth) intake and need for enteral feeds...Date Initiated: 11/06/2019, Revision on: 04/15/2021." Under "Interventions/Tasks" it documented in part, "Notify physician and responsible party of significant weight changes, Date Initiated: 11/06/2019" and "Weights as ordered, Date Initiated: 11/06/2019..." The care plan further documented, "Need for feeding tube/potential for complications of feeding tube use related to aspiration potential, swallowing impairment d/t (due to) CVA (stroke). Feeding tube used for supplemental nutrition and for flushes. Tolerating regular po (by mouth) diet Resident will put her head of bed in flat position, Date Initiated: 11/21/2020. Revision on 11/21/2020." Under "Interventions/Tasks" it documented in part, "Monitor weights and report significant changes, Date Initiated: 09/10/2020..." The care plan for Resident #82 documented, "Cardiac disease related to AFib (3)...Date Initiated: 11/07/2019, Revision on: 06/10/2020." Under "Interventions/Tasks" it documented in part, "Obtain weights as indicated and report significant changes, Date Initiated: 02/20/2020..."

The weight summary for Resident #82 documented the most recent weight obtained was on 5/8/2021 with Resident #82 weighing 155 pounds.

The physician order summary dated 10/1/2021 failed to evidence an order for weight monitoring for Resident #82.

The clinical record for Resident #82 failed to evidence documentation of resident refusals of weight monitoring.

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The most recent "Nutrition Evaluation" dated 8/11/2021 for Resident #82 documented in part, "...Last weight available from May 2021...Recc (recommendations): ...Obtain weights as ordered..."

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #10, the unit nurse manager. LPN #10 stated that the care plan was a communication tool for the staff to communicate the needs of the residents. LPN #10 stated that the care plan notified the CNA's (certified nursing assistants) of any special needs of the resident. LPN #10 stated that residents were weighed monthly and the weights were documented in the computer. LPN #10 stated that if a resident refused to be weighed they notified the physician and the responsible party. LPN #10 stated that Resident #82 received tube feeding and was important to monitor for weight changes. LPN #10 stated that they did not know why there were no weights for Resident #82 documented after May 2021.

On 10/4/2021 at 10:37 a.m., an interview was conducted with OSM (other staff member) #8, dietician. OSM #8 stated that they tracked all the residents in the facility and monitored the weights for any significant gains or losses. OSM #8 stated that Resident #82 received tube feeding boluses and water flushes through their feeding tube and also ate by mouth. OSM #8 reviewed Resident #82's clinical record and stated that the weights had dropped off after May of 2021. OSM #8 stated that according to the most recent weight in May, Resident #82 was receiving adequate nutritional needs but they would prefer to see documentation of weights more recently

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obtained then that of May of 2021. OSM #8 stated that they advise the staff to document any refusals in the medical record.

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN #8. LPN #8 stated that weights were monitored for residents every month unless they were ordered more frequently. LPN #8 stated that residents who were on tube feeding required monitoring of weights due to being more high risk for weight changes. LPN #8 stated that when residents refused to be weighed they documented in the progress notes. LPN #8 stated that the care plan was not being followed if weights were not being monitored as documented on the care plan.

The facility policy "Weight Management" dated 10/17/2018 documented in part, "...4. Residents are weighed a minimum of monthly, by the 10th of each month with more frequent weights obtained as ordered or deemed necessary. 5. Weights are verified and documented in the medical record as they are obtained..."

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. Hemiplegia: Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles.

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Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

2. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

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>.

4. A. The facility staff failed to implement Resident #153's comprehensive care plan for obtaining and monitoring resident's weights.

Resident #153 was admitted to the facility with diagnoses that included but were not limited to bipolar disease (1) and pressure ulcer of sacral region, stage 4 (2). Resident #153's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 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 M coded Resident #153 as having one stage 4 pressure ulcer present on admission to the

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facility.

On 9/28/2021 at approximately 3:37 p.m., an interview was conducted with Resident #153. Resident #153 stated that they had not been weighed since they were admitted to the facility and were not sure if they had lost or gained weight. Resident #153 stated that they never refused for staff to weigh them but at times they had asked for them to come back later.

The comprehensive care plan for Resident #153 documented in part, "NUTRITION: [Name of Resident #153] is at nutritional risk r/t (related to) increased metabolic demands of wound healing, w/ (with) quadriplegia (3), PU (pressure ulcer) stage 4 on sacrum...Date Initiated: 02/17/2021, Revision on: 09/27/2021." Under "Interventions/Tasks" it documented in part, "Obtain weights as ordered, monitor for weight loss and weight changes, Date Initiated: 02/17/2021..."

The weight summary for Resident #153 documented the most recent weight obtained on 3/26/2021 with Resident #153 weighing 197 pounds.

The physician order summary dated 10/1/2021 failed to evidence an order for weight monitoring for Resident #153.

The clinical record for Resident #153 failed to evidence documentation of resident refusals for weight monitoring.

The most recent "Nutrition Evaluation" dated 2/15/2021 for Resident #153 documented in part, "...Spoke to resident who reports fine appetite,

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dislikes food provided. Resident reports ordering out food for all meals, states she does not eat what is provided. Obtained some food preferences, kitchen made aware. Instructed resident on how to call kitchen and request items. Denies issues chewing/swallowing, n/v, constipation or diarrhea. Recommend provide diet as ordered: regular. Obtain weights as ordered, monitor for weight loss and weight changes. Provide food preferences as desired...."

The progress notes for Resident #153 documented in part the following:
- "9/16/2021 12:37 (12:37 p.m.) ...Skin: Stage 4 PU to sacrum. No current weight. Last weight: 197.0# (3/26/21)... Needs increased due to wound healing needs. Recs: (recommendations) -Continue CCHO [constant carbohydrate or controlled carbohydrate] diet for BG (blood glucose) control, supplements for wound healing. -Monitor for changes and update POC (plan of care) as clinically indicated."

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #10, the unit nurse manager. LPN #10 stated that the care plan was a communication tool for the staff to communicate the needs of the residents. LPN #10 stated that the care plan notified the CNA's (certified nursing assistants) of any special needs of the resident. LPN #10 stated that residents were weighed monthly and the weights were documented in the computer. LPN #10 stated that if a resident refused to be weighed they notified the physician and the responsible party. LPN #10 stated that Resident #153 frequently refused care and their weights and there should be progress notes documenting the refusals in the medical record.

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On 10/4/2021 at 10:37 a.m., an interview was conducted with OSM (other staff member) #8, dietician. OSM #8 stated that they tracked all the residents in the facility and monitored the weights for any significant gains or losses. OSM #8 stated that they were advised by staff that Resident #153 refused their weights and they encouraged them to document the refusals in the medical record. OSM #8 stated that Resident #153 was at risk for nutritional deficiencies because of the pressure ulcer and the sporadic weight documentation. OSM #8 stated that they would prefer to have a current weight to monitor Resident #153.

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN #8. LPN #8 stated that weights were monitored for residents every month unless they were ordered more frequently. LPN #8 stated that residents who had pressure ulcers required monitoring of weights due to being more high risk. LPN #8 stated that when residents refused to be weighed they documented in the progress notes. LPN #8 stated that the care plan was not being followed if weights were not being monitored as documented on the care plan.

The facility policy "Weight Management" dated 10/17/2018 documented in part, "...4. Residents are weighed a minimum of monthly, by the 10th of each month with more frequent weights obtained as ordered or deemed necessary. 5. Weights are verified and documented in the medical record as they are obtained...The entire interdisciplinary team must be involved in the resident's care needs to manage unplanned weight change. Each member performs tasks

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consistent with their area of expertise."

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

4. B. The facility staff failed to implement Resident #153's comprehensive care plan to provide treatments as ordered to Resident #153's pressure ulcer.

The comprehensive care plan for Resident #153 documented in part, "SKIN: [Resident #153] has actual skin breakdown related to sacral pressure ulcer on admission and trauma to left ischium. At risk for further impairment r/t (related to) impaired mobility; incontinence Date Initiated: 02/23/2021, Revision on: 6/14/2021." Under "Interventions/Tasks" it documented in part, "[Name of Wound Care] NP (nurse practitioner) wound care to follow and treatments as ordered Date Initiated: 03/30/2021..."

On 9/28/2021 at approximately 3:37 p.m., an interview was conducted with Resident #153. Resident #153 stated that they had an area on their buttocks that they were admitted with that required dressing changes. Resident #153 stated that most of the time the day nurses changed the dressing to the area but there were days when the dressing did not get changed on the evenings or when the wound nurse was off. Resident #153 stated that they did not refuse wound care because they wanted the area to heal so they would be able to go home.

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The physician orders for Resident #153 documented in part, "SACRUM: Cleanse with dakins, pack with hydrogel AND NS (normal saline) soaked PACKINH [sic] STRIPS, cover with boarder [sic] foam gauze every day and evening shift for wound care please use the packing strips, as the roll gauze is too large to pack into her wound AND as needed for soilage please use the packing strips, as the roll gauze is too large to pack into her wound AND one time only for wound care for 1 Day please use the packing strips, as the roll gauze is too large to pack into her wound. Order Date: 9/2/2021."

The eTAR (electronic treatment administration record) for Resident #153 dated 8/1/2021-8/31/2021 failed to evidence the physician ordered treatment was completed to the sacral pressure ulcer on 8/5/2021 on the 7-3 shift, 8/9/21 on the 3-11 shift, 8/9/21 on the 3-11 shift, 8/10/21 on the 7-3 shift, 8/27/21 on the 3-11 shift, and 8/28/21 on the 7-3 shift.

The eTAR for Resident #153 dated 9/1/2021-9/30/2021 failed to evidence the treatment completed to the sacral pressure ulcer on 9/7/21 on the 7-3 shift, 9/11/21 on the 7-3 and 3-11 shift, on 9/13/21 on the 3-11 shift, 9/17/21 on the 3-11 shift, 9/21/21 on the 3-11 shift, 9/25/21 on the 3-11 shift and 9/26/21 on the 7-3 shift.

On 9/30/2021 at 12:26 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the wound nurse. LPN #4 stated that they performed wound care for Resident #153 on day shift every other weekend and most weekdays. LPN #4 stated when they were not working the floor nurses completed the wound care. LPN #4 stated that the wound care was documented as

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F 656	Continued From page 121 performed on the eTAR and refusals of wound care were witnessed by another staff member and documented in the progress notes. LPN #4 reviewed the blanks for physician ordered treatments on the eTARs for Resident #153 for August and September of 2021, as listed above, and stated that they could not evidence that the wound care was completed without documentation to support it. LPN #4 stated that the care plan was not being implemented if treatments were not being administered as ordered. On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN #10, the unit nurse manager. LPN #10 stated that the care plan was a communication tool for the staff to communicate the needs of the residents. LPN #10 stated that the care plan notified the CNA's (certified nursing assistants) of any special needs of the resident. LPN #10 stated that the treatments were evidenced as completed by documenting on the eTAR or in the progress notes. LPN #10 stated that they could not determine if the wound care was completed or not signed off on the blank dates on the eTARs in August and September of 2021 for Resident #153. LPN #10 stated that the care plan was not being implemented if treatments were not being administered as ordered. On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN #8. LPN #8 stated that wound care completion was evidenced by documentation on the eTAR and refusals of wound care were documented on the eTAR or the progress notes. LPN #8 if there was no documentation that the wound care was completed on the eTAR or in the progress notes	F 656		

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they could not say that the wound care was completed. LPN #8 stated that if the wound care was not completed the care plan for treatments as ordered was not being implemented.

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. 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.

2. Pressure ulcer: is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and

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sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

3. Quadriplegia: "Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia." This information is taken from the website https://medlineplus.gov/paralysis.html.

5. The facility staff failed to implement Resident #145's comprehensive care plan for the administration of oxygen at the physician ordered rate.

Resident #145 was admitted on 9/3/21 with the diagnoses of but not limited to COVID-19, respiratory failure, atrial fibrillation, and hypothyroidism. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 9/9/21. The resident was code as being cognitively impaired in ability to make daily life decisions. Resident #145 was coded as requiring extensive assistance for bathing, hygiene, toileting, dressing, and bed mobility; and limited assistance for transfers and eating.

On 9/28/21 at 12:53 PM, an observation of Resident #145 and the resident's oxygen was conducted. The resident was observed receiving

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F 656	Continued From page 124 oxygen via a nasal cannula that was connected to an oxygen concentrator that was running. The oxygen concentrator flow rate was set at 1 liter per minute, as evidenced by the flow meter ball set on the 1 liter line with the line positioned through the center of the flow meter ball. A review of the clinical record revealed a physician's order dated 9/4/21 for "Oxygen Therapy Oxygen at: 2 Liters/minute Via: NC (nasal cannula)." A review of the comprehensive care plan revealed one dated 9/13/21 for "Has/At risk for respiratory impairment related to covid 19. acute respiratory failure with hypoxia." This care plan included an intervention dated 9/13/21 for "Administer oxygen per physician order." On 10/4/2021 at 2:15 p.m., an interview was conducted with RN (Registered Nurse) #2, the MDS nurse. RN #2 stated that the purpose of the care plan was to direct the care of the individual patient. On 10/4/21 at 2:30 PM, an interview was conducted with LPN #8 (Licensed Practical Nurse), the unit manager. When asked if the oxygen was set at 1 liter and the order was for 2 liters, was the oxygen being administered as ordered, she stated it was not. When asked if the care plan documented to administer oxygen as ordered, was the care plan being followed, she stated that it was not being followed. On 10/4/21 at 5:00 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, was made aware of the findings. No further information was provided by	F 656		

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the end of the survey.

6. The facility staff failed to develop a comprehensive care plan for the use of an incentive spirometer for Resident #165

Resident #165 was admitted to the facility on 9/8/21 with the diagnoses of but not limited to atrial fibrillation, stroke, aphasia, dysphagia, high blood pressure, diabetes, and hypothyroidism. The Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/16/21 coded Resident #165 as cognitively impaired in ability to make daily life decisions. Resident #165 was coded as requiring extensive care for bathing, hygiene, toileting, and transfers; limited assistance for dressing and eating; and was coded as incontinent of bowel and bladder.

On 9/28/21 at 12:50 PM, Resident #165 was observed up in his wheelchair in his room eating lunch. An uncovered incentive spirometer was observed on the over-bed table.

On 9/29/21 at 8:45 AM, Resident #165 was observed in his wheelchair in his room. The incentive spirometer was still on the over-bed table, uncovered. When asked if he uses the incentive spirometer, Resident #165 stated that he uses it sometimes.

A review of the clinical record revealed a physician's order dated 9/14/21 for "Incentive Spirometry Instruct Resident - Place the mouthpiece in your mouth, sealing your lips around it. Breathe in as slowly and deeply as possible. Try to raise the piston toward the top of the column and continue to hold for ~

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(approximately) 3 seconds before exhaling. Cough between breaths. Perform 10 repetitions and 5 sets cough between sets."

A review of Resident #165's comprehensive care plan failed to reveal one for the use and care of an incentive spirometer.

On 10/4/2021 at 2:15 p.m., an interview was conducted with RN (Registered Nurse) #2, the MDS nurse. RN #2 stated that the purpose of the care plan was to direct the care of the individual patient.

On 10/4/21 at 2:30 PM, an interview was conducted with LPN #8 (Licensed Practical Nurse), the unit manager. When asked if the use and care of an incentive spirometer should be care planned, she stated that it should be care planned.

On 10/4/21 at 5:00 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, was made aware of the findings. No further information was provided by the end of the survey.
7. The facility staff failed to implement the comprehensive care plan to administer treatments as ordered to Resident #22's pressure injuries.

Resident #22 was admitted to the facility on 7/5/21. Resident #22's diagnoses included but were not limited to multiple sclerosis (1), seizures and major depressive disorder. Resident #22's quarterly minimum data set assessment with an assessment reference date of 9/24/21, coded the resident's cognition as severely impaired.
Section M coded Resident #22 as having two

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F 656	Continued From page 127 stage 3 pressure injuries (2). Review of Resident #22's clinical record revealed the resident was admitted with a stage 3 pressure injury on the right medial heel. Further review of Resident #22's clinical record revealed Resident #22 acquired a stage 2 pressure injury (2) on the sacrum (left buttock) on 8/17/21. Resident #22's comprehensive care plan dated 7/6/21 documented, "Actual skin breakdown related to impaired mobility, admitted with pressure ulcer (injury) to sacrum, right medial heel wound. Potential for further impairment r/t (related to) decreased mobility, weakness, incontinence, nutritional needs. Administer treatment per physician orders..." A physician's order dated 7/6/21 documented an order to cleanse the right medial heel with normal saline, apply Santyl (3), apply calcium alginate (4) and cover with a dry dressing daily. Review of Resident #22's clinical record failed to reveal this treatment was provided on 7/6/21, 7/8/21, 7/10/21 and 7/11/21, as evidenced by blank spaces on the July 2021 TAR [treatment administration record] and no nurses' notes documenting the treatment was done. This treatment was discontinued on 7/14/21. A physician's order dated 7/15/21 documented an order to cleanse the right medial heel with normal saline, apply medihoney (5), apply calcium alginate and secure with bordered gauze every day. Review of Resident #22's clinical record failed to reveal this treatment was provided on 7/19/21 and 8/3/21, as evidenced by blank spaces on the July 2021/August 2021 TARs and no nurses' notes documenting the treatment was	F 656		

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done. This treatment was discontinued on 8/14/21.

A physician's order dated 8/15/21 documented an order to cleanse the right medial heel with normal saline, apply medihoney, apply silver alginate (4) and secure with bordered gauze every day. Review of Resident #22's clinical record failed to reveal this treatment was provided on 8/25/21, 8/28/21, 8/29/21, 8/31/21, 9/1/21, 9/7/21 and 9/9/21, as evidenced by blank spaces on the August 2021/September 2021 TARs and no nurses' notes documenting the treatment was done.

A physician's order dated 8/24/21 documented an order to cleanse the left buttock with normal saline, apply medihoney and secure with bordered gauze every day. Review of Resident #22's clinical record failed to reveal this treatment was provided on 8/29/21, 9/1/21, 9/7/21 and 9/9/21, as evidenced by blank spaces on the August 2021/September 2021 TARs and no nurses' notes documenting the treatment was done.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated the facility employs wound care nurses but the nurses on the medication carts need to provide wound care if the wound care nurses are not available. LPN #7 stated wound care treatments should be documented on the TAR. LPN #7 further stated nurses cannot say treatment was provided if it is not documented. In regards to the purpose of a care plan, LPN #7 stated, "A care plan is individualized to each patient; how best for us to take care of them, especially since we have so much agency. It's a

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great resource for them so they can get to know the patient by looking at the paper..."

On 10/4/21 at 3:30 p.m., another interview was conducted with LPN #7, regarding care plan implementation. LPN #7 stated, "I guess it really depends on the nurse. When I'm taking care of residents, I look at their chart and their care plan, especially when I don't really know."

On 10/4/21 at 4:40 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.

References:

(1) "Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells." 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=ms&_ga=2.53710894.747995928.1633538618-221748656.1633538618

(2) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition,

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perfusion, co-morbidities and condition of the soft tissue.
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.
Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present."
This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf

(3 "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information is taken from the manufacturer's website https://www.santyl.com/.

(4) "Alginate dressings are absorbent wound care products that contain sodium and calcium fibers derived from seaweed. They come in the form of flat dressings that can be placed over open ulcers and rope dressings that are used for packing the wound, which absorb fluids and promote healing with pressure ulcers, diabetic foot ulcers, or venous ulcers. An individual dressing is able to absorb up to 20 times its own weight. These dressings, which are easy to use, mold themselves to the shape of the wound, which helps ensure that they absorb wound drainage properly. This also makes these dressings ideal for using on ulcers in areas that are difficult to dress, such as heels and sacral areas." This information is taken from the website https://advancedtissue.com/2015/09/treating-wou

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F 656	Continued From page 131 nds-with-absorbent-alginate-dressings/. (5) Medihoney is medical grade honey used for wound treatment. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/	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. (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	F 657	1. Resident #160 no longer resides in the center. Resident #22, #45, #82, #153, #145 and #165 care plans have been updated to represent comprehensive plan of care. 2. Ensure all current residents residing in center reviewed to ensure comprehensive care plan is established and implemented. 3. DON or designee will educate all facility nursing staff to ensure understanding and requirements for implementation of comprehensive care plans. 4. DON or designee will audit 10% of all residents to ascertain development and implementation of comprehensive care plan weekly times 4 weeks and monthly times 2 to ensure facility maintains the development/Implementation of comprehensive care Plans. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 657	Continued From page 132 by: Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to review and revise the comprehensive care plan for eight of 84 residents in the survey sample, Residents #502, #91, #111, #65, #21, #19, #155, and #47. 1. The facility staff failed to review and revise Resident #502's comprehensive care plan to address the resident being found physically restrained on 5/6/21, and the resident care needs post the incident. 2. The facility staff failed to review and revise Resident #91's comprehensive care plan following the resident's angry outburst, during which he fractured his hand by punching a hole in his wall on 6/21/21. 3. The facility staff failed to review and revise Resident #111's comprehensive care plan after the resident fell on 7/6/21 and 7/7/21. 4. The facility staff failed to review and revise Resident #65's comprehensive care plan after the resident fell on 6/17/21, 6/24/21 and 6/25/21. 5. The facility staff failed to review and revise Resident #21's comprehensive care plan for the use of bed rails. 6. The facility staff failed to review and revise Resident #19's comprehensive care plan after the resident fell on 1/5/21, 2/16/21 and 3/15/21. 7. The facility staff failed to review and revise the comprehensive care plan for Resident #155 to include the use of bed rails. 8. The facility staff failed to review and/or revise Resident #47's comprehensive care plan to address the discontinuation of dialysis services for the resident.	F 657		

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The findings include:

1. Resident #502 was admitted to the facility on 4/27/16, and most recently readmitted on 12/9/20, with diagnoses including dementia with behaviors and arthritis. She was discharged from the facility on 6/12/21.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/21, Resident #502 was coded as being severely cognitively impaired for making daily decisions, having scored one out of 15 on the BIMS (brief interview for mental status). She was coded as not being placed in physical restraints during the look back period.

A review of Resident #502's clinical record revealed the following progress note, dated 5/6/21: "[Resident #502] was observed with wristband attached to the arm rail of her bed via article of clothing. The wristband was removed and a skin assessment was completed. No integrity issues noted."

A review of Resident #502's comprehensive care plan dated 5/11/16 and updated 6/26/16 revealed no update regarding the resident being placed in physical restraints.

On 9/30/21 at 11:52 a.m., LPN (licensed practical nurse) #15 was interviewed. She stated a resident's care plan incorporates orders and interventions necessary to provide care for a resident. When asked who is responsible for updating a resident's care plan, LPN #15 stated, "I think it is the nurse manager." She stated it is unclear who is responsible for updating the care plan for an acute event like a fall. LPN #15 stated

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the nurse working with the resident at the time may be responsible for updating the care plan at that time, but she was not certain.

On 9/30/21 at 12:06 p.m., LPN #7, a unit manager, was interviewed. She stated the restraint incident for Resident #502 should have been added to the care plan. LPN #7 stated staff should have been alerted on the care plan to assess the resident's psychosocial well-being, and her skin.

On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to anything that was or was not done prior to her arrival at the facility. When asked if the social worker is involved in updating a resident's care plan, she stated she was not sure.

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked who is responsible for updating a resident's care plan, ASM #2 stated nurses, the social worker, and the MDS nurse may all update a resident's care plan. ASM #2 stated Resident #502's care plan should have been updated with the restraint incident.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns.

A review of the facility policy, "Care Conference," revealed, in part: "The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team which includes, but is not necessarily

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limited to the following personnel:
a. The resident's Attending Physician;
b. The Registered Nurse who has responsibility for the resident;
c. The Dietary Manager/Dietitian;
d. The Social Services Worker responsible for the resident;
e. The Activity Director/Coordinator;
f. Therapists (speech, occupational, recreational, etc.), as applicable;
g. Consultants (as appropriate);
h. The Director of Nursing (as applicable);
i. The Charge Nurse responsible for resident care;
j. Nursing Assistants responsible for the resident's care; and
k. Others as appropriate or necessary to meet the needs of the resident.
3. The resident, the resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan."

No further information was provided prior to exit.

Complaint Deficiency

2. Resident #91 was admitted to the facility on 12/15/20, and most recently readmitted on 8/10/21, with diagnoses including diabetes and right leg amputation. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 8/17/21, Resident #91 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

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F 657	Continued From page 136 A review of Resident #91's clinical record revealed the following note dated 6/21/21: "Resident alert and verbal, observed to be angry at the beginning of the shift. Resident was witnessed punching his left hand on the wall out of anger. Resident complains of left hand swelling, pain, and discomfort on ROM (range of motion)." Further review of Resident #91's clinical record revealed an X-ray performed on 6/21/21 confirmed Resident #91's left hand was broken. A review of Resident #91's comprehensive care plan dated 12/24/20 and updated 8/27/21 failed to reveal information related to the 6/21/21 incident. On 9/30/21 at 11:52 a.m., LPN (licensed practical nurse) #15 was interviewed. She stated a resident's care plan incorporates orders and interventions necessary to provide care for a resident. When asked who is responsible for updating a resident's care plan, she stated: "I think it is the nurse manager." She stated it is unclear who is responsible for updating the care plan for an acute event like a fall. She stated the nurse working with the resident at the time may be responsible for updating the care plan at that time, but she was not certain. On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to anything that was or was not done prior to her arrival at the facility. When asked if the social worker is involved in updating a resident's care plan, she stated she was not sure.	F 657		

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On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked who is responsible for reviewing and revising a resident's care plan, ASM #2 stated nurses, the social worker, and the MDS nurse may all update a resident's care plan. ASM #2 stated Resident #91's comprehensive care plan should have been updated after his angry outburst and hand fracture.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns.

No further information was provided prior to exit.

Complaint Deficiency
3. Resident #111 was admitted to the facility on 5/24/21. Resident #111's diagnoses included but were not limited to diabetes, dementia and anxiety disorder. Resident #111's quarterly minimum data set assessment with an assessment reference date of 8/28/21, coded the resident's cognition as severely impaired. Section J coded Resident #111 as having sustained two or more falls since admission or the prior assessment.

Review of Resident #111's clinical record revealed nurses' notes that documented the resident fell on 7/6/21 and 7/7/21.

Review of Resident #111's comprehensive care plan dated 5/25/21 failed to reveal the care plan was reviewed or revised after the 7/6/21 and 7/7/21 falls.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7.

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LPN #7 stated, "A care plan is individualized to each patient; how best for us to take care of them, especially since we have so much agency. It's a great resource for them so they can get to know the patient by looking at the paper. Also, it's meant to help prevent future incidences such as falls." LPN #7 stated a resident's care plan should be reviewed and revised after each fall.

On 10/4/21 at 11:25 a.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.

4. Resident #65 was admitted to the facility on 11/27/19. Resident #65's diagnoses included but were not limited to diabetes, breast cancer and muscle wasting. Resident #65's quarterly minimum data set assessment with an assessment reference date of 8/5/21, coded the resident's cognition as severely impaired. Section J coded the resident as having sustained two or more falls since admission or the prior assessment.

Review of Resident #65's clinical record revealed nurses' notes that documented Resident #65 fell on 6/17/21, 6/24/21 and 6/25/21.

Review of Resident #65's comprehensive care plan dated 1/11/21 failed to reveal the care plan was reviewed or revised for the 6/17/21, 6/24/21 and 6/25/21 falls.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated, "A care plan is individualized to

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each patient; how best for us to take care of them, especially since we have so much agency. It's a great resource for them so they can get to know the patient by looking at the paper. Also, it's meant to help prevent future incidences such as falls." LPN #7 stated a resident's care plan should be reviewed and revised after each fall.

On 10/4/21 at 11:25 a.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.

5. Resident #21 was admitted to the facility on 8/4/20. Resident #21's diagnoses included but were not limited to a history of stroke, paralysis and diabetes. Resident #21's quarterly minimum data set assessment with an assessment reference date of 7/9/21, coded the resident as being cognitively intact.

On 9/28/21 at 12:21 p.m., Resident #21 was observed lying in bed with two 1/2 bed rails in the upright position.

Review of Resident #21's clinical record revealed a physician's order dated 8/4/20 for two 1/2 bed rails as enablers to turn and reposition.

Review of Resident #21's comprehensive care plan dated 8/5/20 failed to reveal documentation regarding the use of bed rails.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated, "A care plan is individualized to

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each patient; how best for us to take care of them, especially since we have so much agency. It's a great resource for them so they can get to know the patient by looking at the paper..." LPN #7 stated residents' care plans should be reviewed and revised to include the use of bed rails.

On 10/4/21 at 11:25 a.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.

6. Resident #19 was admitted to the facility on 4/10/17. Resident #19's diagnoses included but were not limited to muscle weakness, repeated falls and high blood pressure. Resident #19's quarterly minimum data set assessment with an assessment reference date of 7/8/21, coded the resident's cognition as severely impaired. Section J coded Resident #19 as not having sustained a fall since the prior assessment.

Review of Resident #19's clinical record revealed nurses' notes that documented the resident fell on 1/5/21, 2/16/21 and 3/15/21.

Review of Resident #19's comprehensive care plan dated 11/1/20 failed to reveal the care plan was reviewed or revised for the 1/5/21, 2/16/21 and 3/15/21 falls.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated, "A care plan is individualized to each patient; how best for us to take care of

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them, especially since we have so much agency. It's a great resource for them so they can get to know the patient by looking at the paper. Also, it's meant to help prevent future incidences such as falls." LPN #7 stated a resident's care plan should be reviewed and revised after each fall.

On 10/4/21 at 11:25 a.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.
7. Resident #155 was admitted to the facility with diagnoses that included but were not limited to paraplegia (1) and major depressive disorder (2). Resident #155's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #155 as scoring a 14 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 14- being cognitively intact for making daily decisions.

On 9/28/2021 at 12:30 p.m., an observation was made of Resident #153 in bed with bilateral upper bed rails in place. At that time an interview was conducted with Resident #153 who stated that they used the bed rails to hold on to when positioning.

An additional observation of Resident #153 in bed with bilateral upper side rails in place was conducted on 9/29/2021 at 9:45 a.m.

The comprehensive care plan for Resident #155 documented in part, "ADL (activities of daily living) Self-care deficit related to physical limitations able to participate in UB (upper body)

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activities but dep (dependent) for LB (lower body) activities due to contractures and paraplegia chronic pain syndrome decreased mobility. Date Initiated: 04/19/2021, Revision on: 09/16/2021." The ADL care plan failed to evidence the use of bed rails for Resident #155.

The admission resident evaluation dated 4/9/2021 for Resident #155 documented in part, "...Bed rail risks, benefits, and precautions were discussed with the patient and/or patient representative. Bed rail(s) is/are recommended at this time. Consent obtained from: Patient/Resident..."

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that care plans were a team effort. LPN #8 stated that the nurse manager was responsible for the baseline care plan and the MDS (minimum data set) nurse completed the comprehensive care plan which the nurses could update. LPN #8 stated that residents who utilized bed rails should have them on their care plans.

On 10/4/2021 at 2:15 p.m., an interview was conducted with RN (registered nurse) #2, MDS (minimum data set) nurse. RN #2 stated that the purpose of the care plan was to direct the care of the individual patient. RN #2 stated that the care plans were created by the interdisciplinary team and that they reviewed the CAAS (care area assessment summary) from the MDS assessment to direct the care plans they put into place. RN #2 stated that residents should have a care plan addressing their use of bed rails.

On 10/4/2021 at 3:06 p.m., an interview was conducted with LPN #10, the unit nurse manager.

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LPN #10 stated that the care plan was a communication tool for the staff to communicate the needs of the residents. LPN #10 stated that the care plan notified the CNA's (certified nursing assistants) of any special needs of the resident. LPN #10 stated that bed rails were included in the care plan and were a part of the ADL care plan. LPN #10 stated that Resident #155's care plan should include bed rails because they used them.

On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on care planning. ASM #2 also stated that the facility used Lippincott as their nursing standard of practice.

The facility policy "Care Planning- Interdisciplinary Team" documented in part, "...The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team..."

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 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the

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administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. Paralysis: is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia. This information is taken from the website https://medlineplus.gov/paralysis.html.

2. Major depressive disorder: is a mood disorder. It occurs when feelings of sadness, loss, anger, or frustration get in the way of your life over a long period of time. It also changes how your body works. This information was obtained from the website: https://medlineplus.gov/ency/article/000945.htm.

8. Resident #47 was admitted to the facility on 7/19/21 with the diagnoses of but not limited to metabolic encephalopathy, chronic obstructive pulmonary disease, congestive heart failure, atrial fibrillation, somatoform disorder, angina, depression, insomnia, high blood pressure, end stage renal disease, and dysphagia. The most recent MDS (Minimum Data Set) was an admission/5-day assessment with an ARD (Assessment Reference Date) of 7/22/21. The resident was coded as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive

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assistance for transfers and limited assistance for all other areas of activities of daily living.

A review of the comprehensive care plan revealed one dated 7/20/21 for "(Resident #47) has Renal insufficiency related to chronic renal failure, requires encouragement to attend as resident frequently refuses." This care plan included dialysis-specific interventions of: "Arrange for transportation to and from Dialysis center on Dialysis days" dated 7/20/21; "Check access site for lack of thrill/bruit, evidence of infection, swelling or excessive bleeding per facility guidelines. Report abnormalities to physician" dated 7/20/21; "Confer with physician and/or dialysis treatment center regarding changes in medication administration times/dosage pre-dialysis as needed" dated 7/20/21; and "Coordinate dialysis care with the dialysis treatment center" dated 7/20/21.

As of the survey date 10/4/21, this care plan remained current and active on the clinical record.

A review of the clinical record revealed a nurse's note dated 9/6/21 that documented, "Resident is alert and verbal, dialysis called this AM, writer was advised that resident does not need dialysis due to better labs [laboratory tests] results. Daughter (name) and MD (medical doctor) aware."

Further review of the clinical record revealed a physician's progress note dated 9/17/21 that documented, "The hemodialysis catheter will be removed today."

On 10/4/21 at 2:30 PM, an interview was

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F 657	Continued From page 146 conducted with LPN #8 (Licensed Practical Nurse), the unit manager. She verified that the resident was no longer on dialysis. When asked if the care plan should have been updated to reflect that the resident was no longer on dialysis, LPN #8 stated that it should have been. On 10/4/21 at 5:00 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, was made aware of the findings. No further information was provided by the end of the survey.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to follow professional standards of practice for two of 84 residents in the survey sample, Resident #153, and #129. The facility staff failed to clarify a duplicate physician order for Alpralozem for Resident #153, and failed to transcribe a telephone order for treatment of Resident #129's pressure ulcer. (1) The findings include: 1. Resident #153 was admitted to the facility with diagnoses that included but were not limited to	F 658	1. Resident #129 no longer resides in the center. Resident #153 order was clarified upon notification of finding. 2. Review of all resident's medication orders to ensure free of duplication and all current residents with wounds have accurate treatment orders. 3. DON or designee will educate all facility nursing staff to review policy on clarification of physician orders when duplicates present and transcription of treatment orders for pressure ulcers. 4. DON or designee will audit 10% of all residents to ascertain free of duplicate medication orders and active treatment orders in place for all wounds weekly times 4 weeks and monthly times 2 to ensure facility is executing physician to meet professional standards. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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bipolar disease (1) and pressure ulcer of sacral region, stage 4 (2).

Resident #153's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 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.

The physician order summary dated 9/29/2021 documented in part the following:
- "Alprazolam Tablet 0.5 mg (milligram) Give 2 (two) tablet by mouth two times a day for anxiety. Verbal. Order Date: 09/24/2021."
- "Alprazolam Tablet 0.5 mg Give 2 tablet by mouth two times a day for anxiety related to anxiety disorder, unspecified. Prescriber Entered. Order Date: 09/24/2021."

The eMAR (electronic medication administration record) dated 9/1/2021-9/30/2021 for Resident #153 documented in part the following:
- "Alprazolam Tablet 0.5 mg Give 2 tablet by mouth two times a day for anxiety related to Anxiety Disorder, unspecified. Start Date: 09/25/2021 2100 (9:00 p.m.)." Administered at 0900 (9:00 a.m.) and 2100 (9:00 p.m.) on 9/26/2021, 9/27/2021, 9/28/2021, 9/29/2021 and 9/30/2021.
- "Alprazolam Tablet 0.5 mg Give 2 tablet by mouth two times a day for anxiety. Start Date: 09/24/2021 1700 (5:00 p.m.) D/C (discontinue) Date 09/29/2021 0808 (8:08 a.m.)." Administered at 0900 (9:00 a.m.) and 1700 (5:00 p.m.) on 9/25/2021, 9/26/2021, 9/27/2021 and 9/28/2021.
The eMAR documented Resident #153 receiving Alprazolam 0.5mg at 9:00 a.m., 5:00 p.m., and

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9:00 p.m. on 9/25/21, 9/26/21, 9/27/21 and 9/28/21.

The progress notes for Resident #153 documented in part the following:
- "9/24/2021 15:54 (3:54 p.m.) Note Text: Resident has a new order for a UA C and S (urinalysis with culture and sensitivity) to rule out uti (urinary tract infection) resident also has a new order for her Xanax (Alprazolam) to be changed to two tablet BID (twice a day) orders has been faxed to the pharmacy."
- "9/27/2021 09:34 (9:34 a.m.) ...She is on Xanax twice daily for chronic anxiety."

The controlled substance log for Resident #153 documented staff removing 2 tablets of Alprazolam for Resident #153 on 9/25/21, 9/26/21, 9/27/21 and 9/28/21 at 9:00 a.m., 5:00 p.m. and 9:00 p.m.

The comprehensive care plan for Resident #153 documented in part, "PSYCHOTROPIC MEDICATIONS: [Resident #153] is at risk for adverse effects related to use of anti-depression medication, use of antianxiety/anxiolytic medication, use of antipsychotic medication. Diagnosis of Bipolar disorder and treatment resistant depression. Recently younger sister suddenly died Date Initiated: 02/11/2021. Revision on: 09/27/2021."

On 10/4/2021 at 10:26 a.m., ASM (administrative staff member) #2, the director of nursing stated that the LPN (licensed practical nurse) who worked the day shift on 9/26/21, 9/27/21 and 9/28/21 no longer worked at the facility.

On 10/4/2021 at 3:06 p.m., an interview was

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F 658	Continued From page 149 conducted with LPN #10, the unit nurse manager. LPN #10 stated that new orders were verified by the pharmacy and reviewed for any discrepancies. LPN #10 stated that the nurses also clarified any unusual orders or any discrepancies with medications with the physician. LPN #10 reviewed the eMAR (electronic medication administration record) for Resident #153 dated 9/1/2021-9/30/2021 and stated that there was a duplicate order for Alprazolam on 9/26/21, 9/27/21 and 9/28/21. LPN #10 stated that someone must have clarified the order and discontinued the duplicate on 9/29/2021. LPN #10 stated that the day nurse should have questioned the two 9:00 a.m. doses scheduled for Alprazolam on 9/26/21, 9/27/21 and 9/28/21. On 10/4/2021 at 4:05 p.m., an interview was conducted with LPN #11. LPN #11 stated that they worked the evening shift and had noticed that the time frames for Resident #153's Alprazolam had changed recently. LPN #11 stated that they were administering the Alprazolam at 5:00 p.m. and 9:00 p.m. on their shift but now it was only at 9:00 p.m. LPN #11 reviewed the eMAR dated 9/1/2021-9/30/2021 and stated that Resident #153 was getting the medication three times a day rather than the ordered twice a day because there were two orders. LPN #11 stated that the order should have been clarified. On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM #2 for the facility policy on clarifying the physician orders. ASM #2 also stated that the facility used Lippincott as their nursing standard of practice.	F 658		

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The facility policy "Nursing Policies and Procedures: Physician Documentation Medication/Treatment Orders" dated 8/19/08 documented in part, "Any change to a preexisting order should be clearly stated in the order, e.g. a Coumadin change from 2.0mg to 3.0mg should be written as a) Increase Coumadin to 3.0mg PO daily or b) DC current Coumadin order, Coumadin 3.0mg PO daily...Transcribe the orders using the following steps: a. Clarify the order if necessary...f. For a medication/treatment order change, discontinue the previous entry by writing DC'd and the date. A highlighter may be used to focus attention on the change. Enter the new order on the MAR/TAR as appropriate..."

According to "Fundamentals of Nursing- Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished. Be sure to look for order duplications that could cause your patient to receive a medication in error...."

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. 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

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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.

2. Pressure ulcer: are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000147.htm.

2. Resident #129 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (2) and end stage renal disease (3). Resident #129's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/4/2021, coded Resident #129 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section M documented Resident #129 not having any pressure ulcers.

The progress notes for Resident #129 documented in part the following:
"9/20/2021 06:08 (6:08 a.m.) Note Text: Dr. Breton -- MD (medical doctor) on call for [Name of physician] was contacted regarding pus-like discharge coming from resident's penis. MD stated that she will call back at around 7am."
"9/20/2021 07:49 (7:49 a.m.) Note Text: Penis is split and bleeding, has an area yellow and green in color, with yellow drainage coming from penis,

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with pain 7/10. Nurse called Resident RP (responsible party), [Name of RP], and attempted to leave message. RP VM (voice mail) was not set up. Nurse informed desk nurse this shift who will f/u (follow up) to contacting the resident RP."
"9/20/2021 09:50 (9:50 a.m.)
Physician/Practitioner note... Purulent penile drainage - called [Name of urology practice] urology NP (nurse practitioner) for guidance- very much appreciate recommendations - culture urine today (UA C+S (urinalysis with culture and sensitivity) ordered) - start on cephalosporin (ordered cephalexin 500mg (milligram) BID (twice a day) x10 days, renal dosed) - start topical antibiotic ointment (ordered bactroban application to tip of penis TID (three times a day) x 7 days) - attempt voiding trial -- (ordered voiding trial for tomorrow 9/21/21 - can leave Foley (indwelling urinary catheter) out for 12 hours [sometimes even up to 24 hrs [hours] for those on HD (hemodialysis)] (4) and assess for spontaneous voiding). - will follow up voiding trial with bladder US (ultrasound) to assess residual volume within a few days after voiding trial..."
"9/20/2021 15:19 (3:19 p.m.) Note Text: Resident out to dialysis resident had NP [nurse practitioner] in to see him today to regarding inflamed sore penis NP to add orders for healing in the system awaiting update at this time."
"9/23/2021 09:40 (9:40 a.m.)
Physician/Practitioner note...The wound care NP will also see him today. He is currently applying Bactroban to the penis and taking cephalexin while awaiting urine culture. He reports he is in almost no pain now that the Foley is out..."

The wound care notes for Resident #129 documented in part, "9/23/2021 10:59 (10:59 a.m.)...From foley cath [catheter]. Wound status-

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New, acquired in house? Yes, Etiology- Pressure Ulcer- Stage 3...Cleanse wound with Normal Saline..."

The physician order summary for Resident #129 dated 9/30/2021 failed to evidence an order for a treatment to the pressure ulcer to the posterior penis.

The eMAR (electronic medication administration record) dated 9/1/2021-9/30/2021 for Resident #129 documented Bactroban ointment was applied to the tip of the penis three times a day from 9/20/2021 through 9/27/2021. The eMAR and eTAR (electronic treatment administration record) dated 9/1/2021-9/30/2021 failed to evidence documentation of a treatment to the pressure ulcer after 9/27/2021.

The comprehensive care plan for Resident #129 dated 4/2/2021 documented in part, "At risk for alteration in skin integrity related to history of chronic pressure ulcers, med (medication) use, incontinent episodes... Actual skin impairment as pressure to the posterior penis...Date Initiated: 04/02/2021, Revision on: 09/28/2021."

On 9/30/2021 at 12:26 p.m., an interview was conducted with LPN (licensed practical nurse) #4, wound care nurse. LPN #4 stated that they worked during the weekdays and every other weekend and performed the wound care. LPN #4 stated that they rounded with the wound care nurse practitioner when they came every week to assess wounds. LPN #4 stated that wound care was evidenced by documenting it on the treatment administration record. LPN #4 stated that they were aware that Resident #82 had the pressure ulcer to the penis and that they were to

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clean the area with normal saline, however it was not in the physician orders. LPN #4 stated that they had rounded with the nurse practitioner and knew that was the treatment that she had ordered for the area so she cleaned the area when she was working. LPN #4 stated that other staff would not know to complete the care because there was no order in place. LPN #4 stated that without an order for the treatment and without documentation of treatment on the eTAR they could not evidence that any treatment had been done since 9/27/2021.

On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on transcribing orders.

The facility policy "Nursing Policy and Procedures: Physician Documentation Medication/Treatment Orders" dated 8/19/08 documented in part, "...Each medication/treatment order is documented in the resident's medical record with the date, time and signature of the person writing or receiving the order. The order is recorded on the physician order sheet or the telephone order sheet if it is a verbal order...Transcribe treatment order on the Treatment Administration Record, including all the elements of the order and the date..."

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

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F 658	Continued From page 155 1. Pressure ulcer: are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000147.htm. 2. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . 3. End-stage kidney disease: The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.	F 658		
F 684 SS=E	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	F 684	1. Residents #153 and #82 remain in center weights obtained for month of October. Resident #433 no longer remains in center. 2. Review of all current residents MAR/TAR from 09/01/2021 to current to ensure execution of physician orders.	

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F 684	Continued From page 156 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review it was determined the facility staff failed to ensure the weights were monitored per the comprehensive person-centered plan of care for two of 84 residents in the survey sample, (Resident #153 and Resident #82); and failed to ensure physician ordered wound treatments were provided as ordered for one of 84 residents in the survey sample, (Resident #433). 1. Resident #153 was identified as being at risk nutritionally with interventions to obtain weights, monitor for weight loss and report significant weight loss, and had not been weighed since 3/6/21. 2. Resident #82 was assessed and identified as being at risk nutritionally with interventions to obtain weights, monitor for weight loss and report significant weight loss and had not been weighed since 5/8/21. 3. The facility staff failed to provide the physician ordered treatments to Resident #433's left hip surgical wound on multiple dates during April and May 2021. The findings include: 1. Resident #153 was admitted to the facility with diagnoses that included but were not limited to bipolar disease (1) and pressure ulcer of sacral region, stage 4 (2). Resident #153's most recent MDS (minimum	F 684	3. DON or designee will educate all facility nursing staff to review policy on following physician orders to include documentation requirements. 4. DON or designee will audit 10% of all resident's MAR/TAR weekly times 4 weeks and monthly times 2 to ensure facility fulfills physician orders. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/18/21

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data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 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 K coded Resident #153 as receiving a therapeutic diet while a resident and not having a weight loss or gain in the assessment period.

On 9/28/2021 at approximately 3:37 p.m., an interview was conducted with Resident #153. Resident #153 stated that they had not been weighed since they were admitted to the facility and were not sure if they had lost or gained weight. Resident #153 stated that they never refused for staff to weigh them but at times they had asked for them to come back later.

The comprehensive care plan for Resident #153 documented in part, "NUTRITION: [Name of Resident #153] is at nutritional risk r/t (related to) increased metabolic demands of wound healing, w/ (with) quadriplegia (3), PU (pressure ulcer) stage 4 on sacrum...Date Initiated: 02/17/2021, Revision on: 09/27/2021." Under "Interventions/Tasks" it documented in part, "Obtain weights as ordered, monitor for weight loss and weight changes, Date Initiated: 02/17/2021..."

The weight summary for Resident #153 documented the most recent weight obtained on 3/26/2021 with Resident #153 weighing 197 pounds.

The physician order summary dated 10/1/2021 failed to evidence an order for weight monitoring for Resident #153.

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The clinical record for Resident #153 failed to evidence documentation of resident refusals of weight monitoring.

The most recent "Nutrition Evaluation" dated 2/15/2021 for Resident #153 documented in part, "...Spoke to resident who reports fine appetite, dislikes food provided. Resident reports ordering out food for all meals, states she does not eat what is provided. Obtained some food preferences, kitchen made aware. Instructed resident on how to call kitchen and request items. Denies issues chewing/swallowing, n/v, constipation or diarrhea. Recommend provide diet as ordered: regular. Obtain weights as ordered, monitor for weight loss and weight changes. Provide food preferences as desired...."

The progress notes for Resident #153 documented in part, "9/16/2021 12:37 (12:37 p.m.) ...Skin: Stage 4 PU to sacrum. No current weight. Last weight: 197.0# (3/26/21)... Needs increased due to wound healing needs. Recs: (recommendations) Continue CCHO [consistent carbohydrate] diet for BG (blood glucose) control, supplements for wound healing. -Monitor for changes and update POC (plan of care) as clinically indicated."

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #10, the unit nurse manager. LPN #10 stated that residents were weighed monthly and the weights were documented in the computer. LPN #10 stated that if a resident refused to be weighed they notified the physician and the responsible party. LPN #10 stated that Resident #153 frequently refused care and weights and

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there should be progress notes documenting the refusals in the medical record.

On 10/4/2021 at 10:37 a.m., an interview was conducted with OSM (other staff member) #8, dietician. OSM #8 stated that they tracked all the residents in the facility and monitored the weights for any significant gains or losses. OSM #8 stated that they were advised by staff that Resident #153 refused their weights and they encouraged them to document the refusals in the medical record. OSM #8 stated that Resident #153 was at risk for nutritional deficiencies because of the pressure ulcer and the sporadic weight documentation. OSM #8 stated that they would prefer to have a current weight to monitor Resident #153.

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN #8. LPN #8 stated that weights were monitored for residents every month unless they were ordered more frequently. LPN #8 stated that residents who had pressure ulcers required monitoring of weights due to being more high risk. LPN #8 stated that when residents refused to be weighed they documented in the progress notes.

The facility policy "Weight Management" dated 10/17/2018 documented in part, "...4. Residents are weighed a minimum of monthly, by the 10th of each month with more frequent weights obtained as ordered or deemed necessary. 5. Weights are verified and documented in the medical record as they are obtained...The entire interdisciplinary team must be involved in the resident's care needs to manage unplanned weight change. Each member performs tasks consistent with their area of

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expertise."

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. 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.

2. Pressure ulcer: is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0

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00740.htm.

3. Quadriplegia: "Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia." This information is taken from the website https://medlineplus.gov/paralysis.html.

2. Resident #82 was admitted to the facility with diagnoses that included but were not limited to hemiplegia (1) and cerebral infarction (2).

Resident #82's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/11/2021, coded Resident #82 as scoring a 2 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 2- being severely impaired for making daily decisions. Section K coded Resident #82 as receiving tube feeding and a therapeutic diet while a resident at the facility.

The comprehensive care plan for Resident #82 documented in part, "At potential for nutritional risk r/t (related to) poor po (by mouth) intake and need for enteral feeds...Date Initiated: 11/06/2019, Revision on: 04/15/2021." Under "Interventions/Tasks" it documented in part, "Notify physician and responsible party of significant weight changes, Date Initiated: 11/06/2019" and "Weights as ordered, Date Initiated: 11/06/2019..." The care plan further

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documented, "Need for feeding tube/potential for complications of feeding tube use related to aspiration potential, swallowing impairment d/t (due to) CVA (stroke). Feeding tube used for supplemental nutrition and for flushes. Tolerating regular po (by mouth) diet Resident will put her head of bed in flat position, Date Initiated: 11/21/2020. Revision on 11/21/2020." Under "Interventions/Tasks" it documented in part, "Monitor weights and report significant changes, Date Initiated: 09/10/2020..." The care plan for Resident #82 documented, "Cardiac disease related to AFib (3)...Date Initiated: 11/07/2019, Revision on: 06/10/2020." Under "Interventions/Tasks" it documented in part, "Obtain weights as indicated and report significant changes, Date Initiated: 02/20/2020..."

The weight summary for Resident #82 documented the most recent weight obtained on 5/8/2021 with Resident #82 weighing 155 pounds.

The physician order summary dated 10/1/2021 failed to evidence an order for weight monitoring for Resident #82.

The clinical record for Resident #82 failed to evidence documentation of resident refusals of weight monitoring.

The most recent "Nutrition Evaluation" dated 8/11/2021 for Resident #82 documented in part, "...Last weight available from May 2021...Recc (recommendations): ...Obtain weights as ordered..."

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN (licensed practical nurse) #10, the unit nurse manager. LPN #10 stated

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that residents were weighed monthly and the weights were documented in the computer. LPN #10 stated that if a resident refused to be weighed they notified the physician and the responsible party. LPN #10 stated that Resident #82 received tube feeding and was important to monitor for weight changes. LPN #10 stated that they did not know why there were no weights documented after May 2021.

On 10/4/2021 at 10:37 a.m., an interview was conducted with OSM (other staff member) #8, dietician. OSM #8 stated that they tracked all the residents in the facility and monitored the weights for any significant gains or losses. OSM #8 stated that Resident #82 received tube feeding boluses and water flushes through their feeding tube and also ate by mouth. OSM #8 reviewed Resident #82's clinical record and stated that the weights had dropped off after May of 2021. OSM #8 stated that according to the most recent weight in May, Resident #82 was receiving adequate nutritional needs but they would prefer to see documentation of weights more recently than May of 2021. OSM #8 stated that they advise the staff to document any refusals in the medical record.

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN #8. LPN #8 stated that weights were monitored for residents every month unless they were ordered more frequently. LPN #8 stated that residents who were on tube feeding required monitoring of weights due to being more high risk for weight changes. LPN #8 stated that when residents refused to be weighed they documented in the progress notes.

On 10/4/2021 at approximately 4:30 p.m., ASM

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(administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. Hemiplegia: also called: Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

2. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

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>.

3. Resident #433 was admitted to the facility on 4/23/21 with diagnoses that included but were not limited to: left total hip replacement (surgical replacement of the hip joint) (1), dementia

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F 684	Continued From page 165 (progressive state of mental decline) (2), Parkinson's disease (progressive neurological disorder characterized by resting tremor) (3) and adult failure to thrive (multiple chronic medical conditions of poor nutrition, weight loss, inactivity, depression and decreasing functional ability leading to a downward spiral). (4) The most recent MDS (minimum data set) assessment, a five day Medicare assessment with an ARD (assessment reference date) of 4/28/21, coded the resident as scoring a 06 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired. A review of the MDS Section G-functional status coded Resident #433 as requiring extensive assistance for bed mobility, transfer, locomotion, eating, dressing; total dependence for hygiene / bathing and walking did not occur. A review of MDS Section H- bowel and bladder coded Resident #433 as always incontinent for bowel and for bladder. A review of MDS Section M-Skin Conditions- coded the resident with an unstageable deep tissue injury and surgical wound. A review of Resident #433's comprehensive care plan dated 5/3/21, documents in part, "FOCUS-Alteration in skin integrity related to impaired mobility weakness and incontinent. INTERVENTIONS-Observe skin condition with ADL (activities of daily living) care daily and report abnormalities." The medical record for Resident #433, revealed wound care is documented on the TAR, with no separate tracking sheet. A review of the physician orders dated 4/24/21,	F 684		

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documented in part, "LEFT HIP: Cleanse surgical site with saline and apply island-bordered gauze dressing daily as needed if soiled AND every day shift."

A review of the wound care notes dated 4/26/21, documented in part, "Left hip-etiology surgical wound."

A review of Resident #433's TAR [treatment administration record] for April 2021, failed to evidence wound care was provided as ordered by the doctor to the residents left hip surgical wound on the following dates: "Left hip on 4/24 and 4/25 day shift."

A review of Resident #433's TAR for May 2021, failed to evidence wound care was provided as ordered by the doctor to the residents left hip surgical wound on the following dates: "Left hip on 5/9 and 5/24 day shift."

On 10/04/21 at 11:38 AM an interview was conducted with LPN (licensed practical nurse) #8, the unit manager. When asked who was responsible for completing wound care, LPN #8 stated, "Wound nurses here Monday through Friday. Our scheduler lets us know if someone is covering or if the nurses need to do their own treatment. If something is ordered twice a day, the floor nurse does the treatment. Treatments are documented on the TAR; refusals are documented on the TAR."

On 10/4/21 at 12:20 PM and interview was conducted with LPN #2, the unit manager. When asked who was responsible for wound care, LPN #2 stated, "The wound care nurse or the staff nurse on the medication cart." When asked what

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blanks on the TAR mean, LPN #2 stated, "It means that it wasn't done."

On 9/30/21 at approximately 11:00 AM, ASM (administrative staff member) #2, the director of nursing stated, "Lippincott Nursing Practice, 11th edition, Wolters Kluwer is our standard of practice."

On 10/4/21 at 4:50 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

According to the nursing standard of practice, "A deviation from protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions and actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." (7)

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 271.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 435.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING ______ B. WING ______	C 10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

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F 684	Continued From page 168 Chapman, page 213/345. (7) Lippincott Nursing Practice, 11th edition, Wolters Kluwer, page 15.	F 684		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review, facility document review and in the course of a complaint investigation the facility staff failed to provide the necessary treatment and services, to promote healing of a pressure ulcer for five of 84 residents in the survey sample, Resident #433, Resident #142, Resident #22, Resident #153 and Resident #129. 1. The facility staff failed to provide the physician ordered treatments to Resident #433's sacral pressure injury on multiple dates during April and May 2021. 2. The facility staff failed to provide the physician ordered treatments to Resident #142's left lateral	F 686	1. Residents # 433, #142 and #129 no longer reside in center. Residents #22 and #153 remain in center, provider notified of missed treatments. 2. All current residents with pressure ulcers were audited on 11/01/2021 to ensure completion of wound care treatments. 3. DON or designee will provide facility nursing staff with education on policy regarding completion of wound care to include documentation. 4. DON or designee will audit 10% of all residents with current wounds to ensure completion of wound treatments weekly times 4 weeks and monthly times 2 to ensure that the facility is providing necessary wound care. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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foot (stag), right elbow (stage), sacral (stage) and left lateral heel (what stage it is) pressure injuries on multiple dates during September 2021.

3. The facility staff failed to provide physician ordered treatments for Resident #22's pressure injuries on multiple dates in July 2021, August 2021 and September 2021.

4. The facility staff failed to provide treatments as ordered by the physician on multiple dates in August 2021 and September 2021, to promote healing of a pressure ulcer (1) for Resident #153.

5. The facility staff failed to transcribe a telephone order for pressure ulcer treatment resulting in a failure to provide treatment to promote healing of Resident #129 pressure ulcer (1).

The findings include:

1. Resident #433 was admitted to the facility on 4/23/21 with diagnoses that included but were not limited to: left total hip replacement (surgical replacement of the hip joint) (1), dementia (progressive state of mental decline) (2), Parkinson's disease (progressive neurological disorder characterized by resting tremor) (3) and adult failure to thrive (multiple chronic medical conditions of poor nutrition, weight loss, inactivity, depression and decreasing functional ability leading to a downward spiral). (4)

The most recent MDS (minimum data set) assessment, a five day Medicare assessment with an ARD (assessment reference date) of 4/28/21, coded the resident as scoring a 06 out of 15 on the BIMS (brief interview for mental status)

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score, indicating the resident is severely cognitively impaired. A review of the MDS Section G-functional status coded Resident #433 as requiring extensive assistance for bed mobility, transfer, locomotion, eating, dressing; total dependence for hygiene / bathing and walking did not occur. A review of MDS Section H- bowel and bladder coded Resident #433 as always incontinent for bowel and for bladder. A review of MDS Section M-Skin Conditions- coded the resident with an unstageable deep tissue injury and surgical wound.

A review of Resident #433's comprehensive care plan dated 5/3/21, documents in part, "FOCUS-Alteration in skin integrity related to impaired mobility weakness and incontinent. INTERVENTIONS-Observe skin condition with ADL (activities of daily living) care daily and report abnormalities."

The medical record for Resident #433, revealed pressure ulcer care documented on the TAR, with no separate pressure ulcer tracking sheet.

A review of the physician orders dated 4/24/21, documented in part, "Sacral wound: cleanse wound with saline, apply medihoney (wound emollient) (5) and then calcium alginate (hemostatic) (6). Cover with a boarder foam dressing as needed for if soiled AND every day shift for wound."

A review of the wound care notes dated 4/26/21, documented in part, "Sacrum-etiology is pressure ulcer suspected deep tissue injury."

A review of Resident #433's TAR [treatment administration record] for April 2021, failed to

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evidence wound care was provided as ordered by the physician on the following dates: "Sacrum on 4/26 day shift."

A review of Resident #433's TAR for May 2021, failed to evidence wound care was provided as ordered by the physician on the following dates: "Sacrum on 5/9, 5/24 and 5/26 day shift."

On 10/04/21 at 11:38 AM an interview was conducted with LPN (licensed practical nurse) #8, the unit manager. When asked who was responsible for completing wound care, LPN #8 stated, "Wound nurses here Monday through Friday. Our scheduler lets us know if someone is covering or if the nurses need to do their own treatment. If something is ordered twice a day, the floor nurse does the treatment. Treatments are documented on the TAR; refusals are documented on the TAR."

On 10/4/21 at 12:20 PM and interview was conducted with LPN #2, the unit manager. When asked who was responsible for wound care, LPN #2 stated, "The wound care nurse or the staff nurse on the medication cart." When asked what blanks on the TAR mean, LPN #2 stated, "It means that it wasn't done."

On 9/30/21 at approximately 11:00 AM, ASM (administrative staff member) #2, the director of nursing stated, "Lippincott Nursing Practice, 11th edition, Wolters Kluwer is our standard of practice."

On 10/4/21 at 4:50 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

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The facility policy, "Pressure Injury and Wound Management" dated 2/15, documented in part, "Any resident with a pressure injury or wound will receive treatment and services consistent with accepted standards of practice."

According to the nursing standard of practice, "A deviation from protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions and actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events." (7)

No further information was provided prior to exit.

Complaint deficiency

References:

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 271.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 435.
(4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 213/345.
(5) 2019 Lippincott Drug Guide for Nurses, Wolters Kluwer, page 436.
(6) 2019 Lippincott Drug Guide for Nurses, Wolters Kluwer, page 436.

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(7) Lippincott Nursing Practice, 11th edition, Wolters Kluwer, page 15.

2. The facility staff failed to follow the physician ordered treatments to Resident #142's left lateral foot (stage 2), right elbow (stage 3), sacral (stage 4) and left lateral heel (stage 2) pressure injuries on multiple dates during September 2021.

The medical record for Resident #142, evidences pressure ulcer care is documented on the TAR, with no separate pressure ulcer tracking sheet.

Resident #142 was admitted to the facility on 9/3/21 with diagnoses that included but were not limited to: sepsis (life-threatening organ dysfunction caused by response to a severe infection) (1), respiratory failure (inability of the heart and lungs to maintain an adequate level of gas exchange) (2) and diabetes mellitus (inability of insulin to function normally in the body) (3).

The most recent MDS (minimum data set) assessment, a five day Medicare assessment with an ARD (assessment reference date) of 9/9/21, coded Resident #142 as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, transfer; total dependence for locomotion, eating, dressing, hygiene and walking did not occur. A review of MDS Section H- bowel and bladder coded the resident as colostomy for bowel and indwelling catheter for bladder. A review of MDS Section K- feeding tube- coded as 'yes', Section O- oxygen therapy, trach and suctioning all coded as 'yes'.

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A review of MDS Section M- Skin Conditions- coded the resident as having 1 Stage 2 pressure ulcer, 1 Stage 3 pressure ulcer and 1 Stage 4 pressure ulcer.

On 9/30/21 at 7:32 AM, LPN #4 was observed performing wound care on Resident #142. No concerns with wound care performed were identified.

A review of Resident #142's comprehensive care plan dated 9/13/21, documents in part, "FOCUS-Actual skin breakdown and potential for further breakdown related to diabetes and impaired mobility. INTERVENTIONS- Administer treatment per physician orders."

A review of the physician orders dated 9/4/21, documented in part, "LEFT LATERAL FOOT: cleanse with NS, apply medihoney (wound emollient) (4), skin prep to the peri wound, cover with an ABD, secure with roll gauze and tape every day shift. RIGHT ELBOW: cleanse with normal saline, apply skin prep to the peri wound, cover with a boarder foam every day shift. SACRUM: cleanse area with Dakins (antiseptic) (5), zinc to the peri wound, pack with dakins soaked roll gauze. cover with sacral border foam dressing every day and evening shift."
A review of the physician orders dated 9/6/21, documented in part, "LEFT HEEL: cleanse with NS, apply medihoney to the red area, apply betadine soaked gauze to the necrotic tissue, skin prep the peri wound, cover with an ABD, secure with roll gauze and tape every day shift."

A review of the TAR for September 2021, failed to evidence documentation that the physician ordered wound care documented above was

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provided on the following dates:
"Left lateral foot on: 9/7 day shift (7am-3pm), 9/11 day shift, 9/17 day shift, 9/25 day shift and 9/26 day shift.
Right elbow: on 9/7 day shift, 9/11 day shift, 9/17 day shift and 9/26 day shift.
Sacrum on: 9/5 evening shift (3pm-11pm), 9/7 day shift and evening shift, 9/11 day shift, 9/17 day shift and 9/26 day shift.
Left heel on: 9/7 day shift, 9/11 day shift, 9/17 day shift, 9/25 day shift and 9/26 day shift."

An interview was conducted on 9/30/21 at 12:26 PM with LPN (licensed practical nurse) #4, the wound care nurse. When asked who was responsible for performing wound care, LPN #4 stated, "I'm here 4 days and every other weekend, then agency nurse or just the nurse on the medication cart takes over and does the dressing change. I do it in the morning and the evening nurse does it in the evening." When asked how staff evidence the physician ordered treatments was done, LPN #4 stated, "I chart it in the MAR/TAR (medication administration record/treatment administration record). I document any refusal in the progress note. If it is not on the TAR, then it wasn't done. I don't think we can evidence that treatments were done if not documented."

An interview was conducted on 9/30/21 at 12:46 PM with LPN #3. When asked who was responsible for wound care, LPN #3 stated, "Yes, I work evenings, and if I have the med [medication] cart, I'm assigned to do wound care also, it comes up on the MAR/TAR to do. You document that you did the wound care and there is a code if the resident is out of the room or refuses. If its [MAR/TAR] blank, not sure that it

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always means it wasn't done, it could mean they were out of the room or refused."

On 10/4/21 at 4:50 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

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 524.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 502.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160.
(4) 2019 Lippincott Drug Guide for Nurses, Wolters Kluwer, page 436.
(5) 2019 Lippincott Drug Guide for Nurses, Wolters Kluwer, page 436.

3. The facility staff failed to provide physician ordered treatments for Resident #22's pressure injuries on multiple dates in July 2021, August 2021 and September 2021.

Resident #22 was admitted to the facility on 7/5/21. Resident #22's diagnoses included but were not limited to multiple sclerosis (1), seizures and major depressive disorder. Resident #22's quarterly minimum data set assessment with an assessment reference date of 9/24/21, coded the resident's cognition as severely impaired. Section M coded Resident #22 as two stage 3 pressure injuries (2).

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Review of Resident #22's clinical record revealed the resident was admitted with a stage 3 pressure injury on the right medial heel. Further review of Resident #22's clinical record revealed Resident #22 acquired a stage 2 pressure injury (2) on the sacrum (left buttock) on 8/17/21.

Resident #22's comprehensive care plan dated 7/6/21 documented, "Actual skin breakdown related to impaired mobility, admitted with pressure ulcer (injury) to sacrum, right medial heel wound. Potential for further impairment r/t (related to) decreased mobility, weakness, incontinence, nutritional needs. Administer treatment per physician orders..."

A physician's order dated 7/6/21 documented an order to cleanse the right medial heel with normal saline, apply Santyl (3), apply calcium alginate (4) and cover with a dry dressing daily. Review of Resident #22's clinical record failed to reveal this treatment was provided as ordered on: 7/6/21, 7/8/21, 7/10/21 and 7/11/21, as evidenced by blank spaces on the July 2021 TAR [treatment administration record] and no nurses' notes documenting the treatment was done. This treatment was discontinued on 7/14/21.

A physician's order dated 7/15/21 documented an order to cleanse the right medial heel with normal saline, apply medihoney (5), apply calcium alginate and secure with bordered gauze every day. Review of Resident #22's clinical record failed to reveal this treatment was provided as ordered on: 7/19/21 and 8/3/21, as evidenced by blank spaces on the July 2021/August 2021 TARs and no nurses' notes documenting the treatment was done. This treatment was discontinued on

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8/14/21.

A physician's order dated 8/15/21 documented an order to cleanse the right medial heel with normal saline, apply medihoney, apply silver alginate (4) and secure with bordered gauze every day. Review of Resident #22's clinical record failed to reveal this treatment was provided on 8/25/21, 8/28/21, 8/29/21, 8/31/21, 9/1/21, 9/7/21 and 9/9/21, as evidenced by blank spaces on the August 2021/September 2021 TARs and no nurses' notes documenting the treatment was done.

A physician's order dated 8/24/21 documented an order to cleanse the left buttock with normal saline, apply medihoney and secure with bordered gauze every day. Review of Resident #22's clinical record failed to reveal this treatment was provided on 8/29/21, 9/1/21, 9/7/21 and 9/9/21, as evidenced by blank spaces on the August 2021/September 2021 TARs and no nurses' notes documenting the treatment was done.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated the facility employs wound care nurses but the nurses on the medication carts need to provide wound care if the wound care nurses are not available. LPN #7 stated wound care treatments should be documented on the TAR. LPN #7 further stated nurses cannot say treatment was provided if it is not documented.

On 10/4/21 at 4:40 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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No further information was presented prior to exit.

References:

(1) "Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells." 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=ms&_ga=2.53710894.747995928.1633538618-221748656.1633538618

(2) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue.
Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.
Stage 3 Pressure Injury: Full-thickness skin loss
Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present." This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resm

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gr/online_store/npiap_pressure_injury_stages.pdf

(3) "SANTYL Ointment is an FDA-approved prescription medicine that removes dead tissue from wounds so they can start to heal." This information is taken from the manufacturer's website https://www.santyl.com/.

(4) "Alginate dressings are absorbent wound care products that contain sodium and calcium fibers derived from seaweed. They come in the form of flat dressings that can be placed over open ulcers and rope dressings that are used for packing the wound, which absorb fluids and promote healing with pressure ulcers, diabetic foot ulcers, or venous ulcers." This information is taken from the website
https://advancedtissue.com/2015/09/treating-wounds-with-absorbent-alginate-dressings/.

(5) Medihoney is medical grade honey used for wound treatment. This information was obtained from the website:
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686636/
4. The facility staff failed to provide treatments as ordered by the physician on multiple dates in August 2021 and September 2021, to promote healing of a pressure ulcer (1) for Resident #153.

Resident #153 was admitted to the facility with diagnoses that included but were not limited to bipolar disease (2), pressure ulcer of sacral region, stage 4 and quadriplegia (3).

Resident #153's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 as scoring a 12 on the staff

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assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired for making daily decisions. Section M documented Resident #153 having one stage 4 pressure ulcer present on admission to the facility.

On 9/28/2021 at approximately 3:37 p.m., an interview was conducted with Resident #153. Resident #153 stated that they had an area on their buttocks that they were admitted with that required dressing changes. Resident #153 stated that most of the time the day nurses changed the dressing to the area but there were days when the dressing did not get changed on the evenings or when the wound nurse was off. Resident #153 stated that they did not refuse wound care because they wanted the area to heal so they would be able to go home.

On 10/4/2021 at approximately 2:00 p.m., an observation was conducted of LPN (licensed practical nurse) #23 providing wound care to Resident #153. There were no concerns during the wound care observation.

The comprehensive care plan for Resident #153 documented in part, "SKIN: [Resident #153] has actual skin breakdown related to sacral pressure ulcer on admission and trauma to left ischium. At risk for further impairment r/t (related to) impaired mobility; incontinence Date Initiated: 02/23/2021, Revision on: 6/14/2021." Under "Interventions/Tasks" it documented in part, "[Name of Wound Care] NP (nurse practitioner) wound care to follow and treatments as ordered Date Initiated: 03/30/2021..."

The physician orders for Resident #153 documented in part, "SACRUM: Cleanse with

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dakins, pack with hydrogel AND NS (normal saline) soaked PACKINH [sic] STRIPS, cover with boarder [sic] foam gauze every day and evening shift for wound care please use the packing strips, as the roll gauze is too large to pack into her wound AND as needed for soilage please use the packing strips, as the roll gauze is too large to pack into her wound AND one time only for wound care for 1 Day please use the packing strips, as the roll gauze is too large to pack into her wound. Order Date: 9/2/2021."

The eTAR (electronic treatment administration record) for Resident #153 dated 8/1/2021-8/31/2021 failed to evidence the treatment completed to the sacral pressure ulcer on 8/5/2021 on the 7-3 shift, 8/9/21 on the 3-11 shift, 8/9/21 on the 3-11 shift, 8/10/21 on the 7-3 shift, 8/27/21 on the 3-11 shift, and 8/28/21 on the 7-3 shift.

The eTAR for Resident #153 dated 9/1/2021-9/30/2021 failed to evidence the treatment completed to the sacral pressure ulcer on 9/7/21 on the 7-3 shift, 9/11/21 on the 7-3 and 3-11 shift, on 9/13/21 on the 3-11 shift, 9/17/21 on the 3-11 shift, 9/21/21 on the 3-11 shift, 9/25/21 on the 3-11 shift and 9/26/21 on the 7-3 shift.

Review of the nurses' notes for the dates documented above failed to evidence any documentation of wound care and or resident refusals for wound care.

On 9/30/2021 at 12:26 p.m., an interview was conducted with LPN (licensed practical nurse) #4, wound nurse. LPN #4 stated that they performed wound care for Resident #153 on day shift every other weekend and most weekdays. LPN #4

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stated when they were not working the floor nurses completed the wound care. LPN #4 stated that the wound care was documented as performed on the eTAR and refusals of wound care were witnessed by another staff member and documented in the progress notes. LPN #4 reviewed the blanks on the eTARs for Resident #153 for August and September of 2021 listed above and stated that they could not evidence that the wound care was completed without documentation to support it. LPN #4 stated that there were times when Resident #153 refused wound care and they documented it in the medical record and had another staff member witness the refusal.

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN #10, the unit nurse manager. LPN #10 stated that the treatments were evidenced as completed by documenting on the eTAR or in the progress notes. LPN #10 stated that they could not determine if the wound care was completed or not signed off on the blank dates on the eTARs in August and September of 2021 for Resident #153. LPN #10 stated that Resident #153 refused wound care at times and it should be documented in the medical record.

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN #8. LPN #8 stated that wound care completion was evidenced by documentation on the eTAR and refusals of wound care were documented on the eTAR or the progress notes. LPN #8 if there was no documentation that the wound care was completed on the eTAR or in the progress notes they could not say that the wound care was completed.

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On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for the facility policy on wound care.

The facility policy "Nursing Policy and Procedure Manual: Assessment & Documentation, Pressure Injury and Wound management" dated 02/2015 documented in part, "...Any resident with a pressure injury or wound will receive treatment and services consistent with accepted standards of practice, research-driven clinical guidelines, interdisciplinary involvement and the resident ' s goals of treatment...."

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. Pressure ulcer: is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that

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there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.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.

3. Quadriplegia: "Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia." This information is taken from the website https://medlineplus.gov/paralysis.html.

5. The facility staff failed to transcribe a telephone order for pressure ulcer treatment resulting in a failure to provide treatment to promote healing of Resident #129 pressure ulcer (1).

Resident #129 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (2) and end stage renal disease (3).

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Resident #129's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/4/2021, coded Resident #129 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section M documented Resident #129 not having any pressure ulcers.

On 9/29/2021 at approximately 4:00 p.m., an interview was conducted with Resident #129. Resident #129 stated that staff applied an ointment to the area on the penis where the Foley catheter used to be but he was not sure how often they did it. Resident #129 stated that the area was healing.

The comprehensive care plan for Resident #129 dated 4/2/2021 documented in part, "At risk for alteration in skin integrity related to history of chronic pressure ulcers, med (medication) use, incontinent episodes... Actual skin impairment as pressure to the posterior penis...Date Initiated: 04/02/2021, Revision on: 09/28/2021." Under "Interventions/Tasks" it documented in part, "Treatment as directed, Date Initiated: 07/08/2021..."

The physician order summary for Resident #129 dated 9/30/2021 failed to evidence an order for a treatment to the pressure ulcer to the posterior penis.

The progress notes for Resident #129 documented in part the following:
"9/20/2021 06:08 (6:08 a.m.) Note Text: Dr. Breton -- MD (medical doctor) on call for [Name of physician] was contacted regarding pus-like

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F 686	Continued From page 187 discharge coming from resident's penis. MD stated that she will call back at around 7am." "9/20/2021 07:49 (7:49 a.m.) Note Text: Penis is split and bleeding, has an area yellow and green in color, with yellow drainage coming from penis, with pain 7/10. Nurse called Resident RP (responsible party), [Name of RP], and attempted to leave message, RP VM (voice mail) was not set up. Nurse informed desk nurse this shift who will f/u (follow up) to contacting the resident RP." "9/20/2021 09:50 (9:50 a.m.) Physician/Practitioner note... Purulent penile drainage - called [Name of urology practice] urology NP (nurse practitioner) for guidance- very much appreciate recommendations - culture urine today (UA C+S (urinalysis with culture and sensitivity) ordered) - start on cephalosporin (ordered cephalexin 500mg (milligram) BID (twice a day) x10 days, renal dosed) - start topical antibiotic ointment (ordered bactroban application to tip of penis TID (three times a day) x 7 days) - attempt voiding trial – (ordered voiding trial for tomorrow 9/21/21 - can leave Foley (indwelling urinary catheter) out for 12 hours [sometimes even up to 24 hrs [hours] for those on HD (hemodialysis)] (4) and assess for spontaneous voiding). - will follow up voiding trial with bladder US (ultrasound) to assess residual volume within a few days after voiding trial..." "9/20/2021 15:19 (3:19 p.m.) Note Text: Resident out to dialysis resident had NP in to see him today to regarding inflamed sore penis NP to add orders for healing in the system awaiting update at this time." "9/23/2021 09:40 (9:40 a.m.) Physician/Practitioner note...The wound care NP will also see him today. He is currently applying Bactroban to the penis and taking cephalexin while awaiting urine culture. He reports he is in	F 686		

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almost no pain now that the Foley is out..."

The wound care notes for Resident #129 documented in part, "9/23/2021 10:59 (10:59 a.m.)...From foley cath [catheter], Wound status- New, acquired in house? Yes, Etiology- Pressure Ulcer- Stage 3...Cleanse wound with Normal Saline..."

The eMAR (electronic medication administration record) dated 9/1/2021-9/30/2021 for Resident #129 documented Bactroban ointment applied to the tip of the penis three times a day from 9/20/2021 through 9/27/2021.

The eMAR and eTAR (electronic treatment administration record) for Resident #129 dated 9/1/2021-9/30/2021 failed to evidence documentation of a treatment to the pressure ulcer after 9/27/2021.

On 9/30/2021 at 12:26 p.m., an interview was conducted with LPN (licensed practical nurse) #4, wound care nurse. LPN #4 stated that they worked during the weekdays and every other weekend and performed the wound care. LPN #4 stated that they rounded with the wound care nurse practitioner when they came every week to assess wounds. LPN #4 stated that wound care was evidenced by documenting it on the treatment administration record. LPN #4 stated that they were aware that Resident #129 had the pressure ulcer to the penis and that they were to clean the area with normal saline, however it was not in the physician orders. LPN #4 stated that they had rounded with the nurse practitioner and knew that was the treatment that she had ordered for the area so she cleaned the area when she was working. LPN #4 stated that other staff

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would not know to complete the care because there was no order in place. LPN #4 stated that without an order for the treatment and without documentation of treatment on the eTAR they could not evidence that any treatment had been done since 9/27/2021.

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN #10, the unit nurse manager. LPN #10 stated that the treatments were evidenced as completed by documenting on the eTAR or in the progress notes. LPN #10 stated that they could not determine if the wound care was completed if there was no order for a treatment.

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN #8. LPN #8 stated that the floor nurses completed wound care when the wound nurse was not there and on evening and night shift. LPN #8 stated that the treatments were signed off on the treatment administration record to evidence that they were completed and could not be evidenced as completed if not ordered.

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

No further information was provided prior to exit.

References:

1. Pressure ulcer: are also called bedsores, or pressure sores. They can form when your skin and soft tissue press against a harder surface, such as a chair or bed, for a prolonged time. This

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F 686	Continued From page 190 pressure reduces blood supply to that area. Lack of blood supply can cause the skin tissue in this area to become damaged or die. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000147.htm. 2. Cerebrovascular disease, infarction or accident: A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . 3. End-stage kidney disease The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. 4. Hemodialysis: Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689	1. Residents #111, #65, #19 remain in facility and care plan reviewed to ensure implementation of appropriate fall interventions. Resident #40 remains in facility provided with schedule for smoking times to enable supervision.	

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F 689	Continued From page 191 §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 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide supervision, and interventions to prevent accidents for four of 84 residents in the survey sample, Residents #111, #65, #19, and #40. The facility staff failed to address and/or implement fall prevention interventions to prevent further falls, for Resident #111 after the resident fell on 7/6/21 and 7/7/21, for after Resident #65 after the resident fells on 6/17/21, 6/24/21 and 6/25/21 and for Resident #19, after the resident fell on 1/5/21, 2/16/21 and 3/15/21; and failed to provide supervision to Resident #40 while he smoked on 9/28/21. Resident #40 was assessed as requiring supervision while smoking for his safety. The findings include: 1. The facility staff failed to address and/or implement fall prevention interventions to prevent further falls, after Resident #111 fell on 7/6/21 and 7/7/21. Resident #111 was admitted to the facility on 5/24/21. Resident #111's diagnoses included but	F 689	2. All resident's safety needs reviewed to ensure facilitation of assistive devices, supervision, and room free of hazards as appropriate. 3. DON or designee will provide facility nursing staff with education on policy regarding following fall precautions and interventions, scheduled smoking times with expectations for supervision and assessment of room to ensure resolution of potential safety hazards. 4. DON or designee will audit 10% of all residents to ensure implementation of assistive devices, supervision with smoking and observation of room environment weekly times 4 weeks and monthly times 2 to ensure facility maintains a safe environment for residents. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will	11/19/21

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were not limited to diabetes, dementia and anxiety disorder. Resident #111's quarterly minimum data set assessment with an assessment reference date of 8/28/21, coded the resident's cognition as severely impaired. Section J coded Resident #111 as having sustained two or more falls since admission or the prior assessment.

Review of Resident #111's clinical record revealed nurses' notes that documented the resident fell on 7/6/21 and 7/7/21.

Review of fall investigations, nurses' notes and Resident #111's comprehensive care plan dated 5/25/21 failed to reveal interventions to prevent future falls were addressed and/or implemented for the 7/6/21 and 7/7/21 falls.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated when a resident falls, the nurses should try to look at that individual person, try to identify the cause of the fall and implement interventions to prevent future falls.

On 10/4/21 at 11:25 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 policy titled, "Falls and Fall Risk, Managing" documented, "3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified."

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No further information was presented prior to exit.

2. The facility staff failed to address and/or implement fall prevention interventions to prevent further falls, after Resident #65 fell on 6/17/21, 6/24/21 and 6/25/21.

Resident #65 was admitted to the facility on 11/27/19. Resident #65's diagnoses included but were not limited to diabetes, breast cancer and muscle wasting. Resident #65's quarterly minimum data set assessment with an assessment reference date of 8/5/21, coded the resident's cognition as severely impaired. Section J coded the resident as having sustained two or more falls since admission or the prior assessment.

Review of Resident #65's clinical record revealed nurses' notes that documented the resident fell on 6/17/21, 6/24/21 and 6/25/21.

Review of fall investigations, nurses' notes and Resident #65's comprehensive care plan dated 1/11/21 failed to reveal interventions to prevent future falls were addressed and/or implemented for the 6/17/21, 6/24/21 and 6/25/21 falls.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated when a resident falls, the nurses should try to look at that individual person, try to identify the cause of the fall and implement interventions to prevent future falls.

On 10/4/21 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2

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(the director of nursing) were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to address and/or implement fall prevention interventions to prevent further falls, after Resident #19 fell on 1/5/21, 2/16/21 and 3/15/21.

Resident #19 was admitted to the facility on 4/10/17. Resident #19's diagnoses included but were not limited to muscle weakness, repeated falls and high blood pressure. Resident #19's quarterly minimum data set assessment with an assessment reference date of 7/8/21, coded the resident's cognition as severely impaired. Section J coded Resident #19 as not having sustained a fall since the prior assessment.

Review of Resident #19's clinical record revealed nurses' notes that documented the resident fell on 1/5/21, 2/16/21 and 3/15/21.

Review of fall investigations, nurses' notes and Resident #19's comprehensive care plan dated 11/1/20 failed to reveal interventions to prevent future falls were addressed and/or implemented for the 1/5/21, 2/16/21 and 3/15/21 falls.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated when a resident falls, the nurses should try to look at that individual person, try to identify the cause of the fall and implement interventions to prevent future falls.

On 10/4/21 at 11:25 a.m., ASM (administrative

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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.

4. The facility staff failed to provide supervision to Resident #40 while he smoked on 9/28/21. Resident #40 was assessed as requiring supervision while smoking for his safety.

Resident #40 was admitted to the facility on 11/28/19 with diagnoses including multiple sclerosis, a brain injury, and drug abuse. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/16/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status).

On 9/28/21 at approximately 10:00 a.m., Resident #502 was observed standing on the sidewalk in front of the facility. He was unsupervised by staff, and he was smoking.

On 9/28/2021 at 12:56 p.m., an interview was conducted with Resident #40. When asked if he smoked, Resident #40 stated that he previously smoked but the facility staff had taken his cigarettes and locked them up. Resident #40 stated that he was not allowed to smoke at the facility and that he only went outside at times to get some fresh air.

On 9/29/21 at 10:10 a.m., Resident #40 was interviewed. He stated he was smoking the previous morning. He stated he had been told by the facility staff not to smoke, and that he could

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not keep smoking materials on his person. However, he stated he had kept the materials in his room before 9/28/21. He stated he had also previously kept smoking materials for another resident, as well. He stated he frequently went outside, without staff supervision, to smoke. He stated he was aware that the facility had become a non-smoking facility. He stated that after the morning of 9/28/21 when he had been observed smoking in front of the facility, ASM (administrative staff member) #1, the administrator, had gone to him and asked him to turn over all smoking materials. He stated he had complied, and ASM #1 removed all smoking materials from his room.

A review of Resident #40's clinical record revealed the following progress notes:

"8/1/2021 14:14 (2:14 p.m.) Nursing/Clinical Note Text: Resident is alert and verbal. No concerns voiced. Has spent most of his time outside frequently caught smoking outside of back door and when addressed denies action. Educated on non-smoking facility but appears to not have retained education. Denies pain and discomfort. Up in wheelchair at this time. Call bell in reach. Will continue to monitor and update as needed."

"9/26/2021 20:00 (8:00 p.m.) Nursing/Clinical Note Text: Writer was making rounds this shift and when returning from the COVID unit writer observed resident along with a female resident on the porch in the front of the building; writer smelled smoke and ask residents if they were smoking; both denied however writer observed this resident to have a cigarette in his left hand; advised resident administration would be notified since we are a non-smoking facility."

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A review of Resident #40's admission smoking safety assessment dated 11/29/19 revealed, in part: "Recommendations: Based on the evaluation, determination is as follows - At risk smoker: Requires staff, family, or friend for physical support or supervision to smoke."

A review of Resident #40's comprehensive care plan dated 5/27/20 and updated 4/13/21, revealed, in part: "Possession of cigarettes/lighter not allowed on premises...Will eliminate unauthorized smoking use/consumption."

On 10/4/21 at 1:50 p.m., LPN (licensed practical nurse) #17 was interviewed. She stated she frequently takes care of Resident #40. She stated she tries to keep an eye on the resident when he goes outside, but cannot provide 1:1 supervision at all times. LPN #17 stated she is not certain whether or not he is smoking when he goes outside. She stated she knows he has a history of smoking when he goes outsideLPN #17 stated the resident should sign out whenever he leaves the facility, but he always stays on facility property. When asked if she was aware of what the resident's smoking safety assessment recommended regarding supervision while he smoked, she stated she was not.

On 10/4/21 at 3:15 p.m., LPN #18 was interviewed. She stated she frequently takes care of Resident #40. She stated the resident's cognition is high enough for him to be go to outside independently. LPN #18 stated the resident is safe on the facility's front porch. She stated she is aware that the resident smokes when he goes outside. She added, "They don't care. They do what they want to do. We are

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having a hard time enforcing [the facility's no smoking policy]."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated no one has deemed the resident unsafe to leave his unit and go to the front of the facility. She stated he is responsible for himself when he leaves the unit. ASM #2 stated a more recent smoking safety evaluation was needed to determine the resident's ability to safely smoke. She stated the facility is a no smoking facility.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. He stated the facility is a no smoking facility. He stated during the COVID-19 outbreak, the rules about smoking had been relaxed. When he arrived at the facility within the past few months, he had started to enforce the policy. ASM #1 stated the facility is actively involved in assisting Resident #40 to transfer to another facility where he will be allowed to smoke, per his request.

A review of the facility policy, "Smoking Policy - Residents," revealed, in part: "6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker. If a smoker, the evaluation will include:
a. Current level of tobacco consumption;
b. Method of tobacco consumption (traditional cigarettes; electronic cigarettes; pipe, etc.);
c. Desire to quit smoking, if a current smoker; and
d. Ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation).
7. The staff shall consult with the Attending

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F 689	Continued From page 199 Physician and the Director of Nursing Services to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. A resident's ability to smoke safely will be re-evaluated quarterly, upon a significant change (physical or cognitive) and as determined by the staff. 9. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. 10. The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. 11. Any resident with restricted smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking." No further information was provided prior to exit. Complaint Deficiency	F 689		
F 695 SS=E	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.	F 695	1. Residents #501 no longer residents in the facility. Resident #22 oxygen tubing was changed. Resident #145 oxygen setting was reviewed to ensure compliance with physician order. Resident #165 incentive spirometer was replaced.	

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F 695	Continued From page 200 This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide respiratory care and services in accordance with professional standards and the resident plan of care for four of 84 residents in the survey sample, Residents #501, #22, #145, and #165. The facility staff administered oxygen to Resident #501 without a physician's order, failed to store Resident #22's oxygen tubing in a clean and sanitary manner; failed to administer oxygen to Resident #145 at the physician ordered rate, and failed to ensure Resident #165's incentive spirometer was maintained in a sanitary manner. The findings include: 1. Resident #501 was admitted to the facility on 6/8/21 with diagnoses including pulmonary hypertension, bladder cancer, prostate cancer, and Parkinson's disease. The resident was not in the facility long enough to have a MDS (minimum data set) assessment completed. On the admission nursing assessment dated 6/8/21, Resident #501 was documented as not having orders for supplemental oxygen, or as receiving supplemental oxygen. Resident #501 expired at the facility on 6/11/21. A review of Resident #501's clinical record revealed the following progress notes: "6/8/2021 18:33 (8:33 p.m.) Resident Evaluation Respiratory: Nail beds are normal. Lips/mucous	F 695	2. All residents receiving oxygen are at risk and have been reviewed to ensure physician order is in place and matches rate administered. All respiratory tubing and incentive spirometers assessed for proper storage. 3. DON or designee will provide facility nursing staff with education on policy regarding administration of oxygen and storage of respiratory supplies to include incentive spirometers. 4. DON or designee will audit 10% of all residents with oxygen and incentive spirometers to ensure order for oxygen provided with matching rate administered and proper storage of tubing and incentive spirometers weekly times 4 weeks and monthly times 2 to ensure that the facility meets standards of practice for respiratory care. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 695	Continued From page 201 membranes appear pink. No respiratory symptoms noted. No oxygen orders are present." "6/9/2021 18:08 (6:08 p.m.) Physician/Practitioner Progress Note When I first entered the room, the resident's sats (oxygen saturations) had dropped to 88% as he was just sitting in bed. The reading was verified. Oxygen via nasal cannula was increased to 3 L NC (liters via nasal cannula) with no significant increase in sats. Resident was placed on a face mask at 3 LNC...Assessment/plan: 1.Acute on chronic hypoxic respiratory failure most likely secondary to severe pulmonary HTN (hypertension). Continue oxygen at 3 L NC continuously." [This note was written by the nurse practitioner. This provider was not available for interview at the time of the survey.] "6/10/2021 12:59 (12:59 p.m.) Physician/Practitioner Progress Note Text: CC (chief complaint): Acute hypoxic respiratory failure, follow up shortness of breath. HPI [history of present illness]: Resident was seen yesterday and was noted to have O2 (oxygen) sats at 88% on 2 LPM [liters per minute] nasal cannula. His oxygen was increased to 4 LPM nasal cannula and his O2 sats improved. A stat (immediate) chest x-ray was ordered and showed no acute process. To best treat his hypoxic respiratory failure, he is to be on 4 LPM by nasal cannula during awake times and 4 LPM via mask while asleep, as he is a mouth breather." A review of Resident #501's physician's orders, medication administration records, and treatment administration records revealed no evidence of oxygen orders.	F 695		

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A review of Resident #501's baseline care plan dated 6/8/21 revealed, in part: "Has/At risk for respiratory impairment...Administer oxygen per physician order."

On 9/30/21 at 11:13 a.m., LPN (licensed practical nurse) #14 was interviewed. She stated Resident #501 received oxygen all the time. She stated she reviews the physician's order to determine the rate of oxygen administration for residents. She stated the resident must have an order for oxygen because oxygen is a medication. LPN #14 stated she could not recall whether or not Resident #501 had an order for oxygen. She stated if there is a problem with an oxygen order, she calls the physician or nurse practitioner to clarify it.

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated she did not find any oxygen orders for Resident #501. She stated she was not certain where the error was. She stated either the nurse practitioner or the nurse had the ability to enter the orders, but it looked like a miscommunication which resulted in neither of them actually entering the orders. ASM #2 stated despite the lack of orders, the nurse practitioner's documentation demonstrated the resident was receiving oxygen all the time. She stated the facility uses Lippincott as its professional standard.

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns.

According to Fundamentals of Nursing, Fifth Edition, Lippincott Williams & Wilkins, 2007, page 851, "Because oxygen is a drug, its use requires a prescription. Policies and standing orders often

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F 695	Continued From page 203 permit the nurse to administer oxygen in emergency situations if the physician is not immediately available to write an order. Although oxygen is generally safe when used properly, certain precautions must be observed. As with all drugs, the potential exists for causing harm with misuse." A review of the facility policy, "Medication/Treatment Orders," revealed, in part: "Medications and/or treatments are administered only upon the clear, complete and written order of a person lawfully authorized to prescribe." No further information was provided prior to exit. Complaint Deficiency 2. The facility staff failed to store Resident #22's oxygen tubing in a clean and sanitary manner. Resident #22 was admitted to the facility on 7/5/21. Resident #22's diagnoses included but were not limited to multiple sclerosis (1), seizures and major depressive disorder. Resident #22's quarterly minimum data set assessment with an assessment reference date of 9/24/21, coded the resident's cognition as severely impaired. Section G coded Resident #22 as totally dependent on staff for bed mobility and transfers. Review of Resident #22's clinical record revealed a physician's order dated 8/31/21 for oxygen at two liters per minute as needed for shortness of breath or a decreased oxygen level. On 9/28/21 at 1:49 p.m. and 9/29/21 at 10:45 a.m., Resident #22 was observed lying in bed, not receiving oxygen. The resident's oxygen concentrator was against the wall and the nasal	F 695		

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cannula oxygen tubing was observed on top of the concentrator. The tubing was not covered and was exposed to air.

On 9/30/21 at 10:37 a.m., an interview was conducted with LPN (licensed practical nurse) #7. LPN #7 stated oxygen tubing should be stored in a sealed bag when not in use so organisms do not grow on it.

Resident #22's comprehensive care plan dated 7/5/21 failed to document information regarding oxygen storage.

On 10/4/21 at 11:25 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 policy titled, "Oxygen Administration" failed to document information regarding oxygen tubing storage.

No further information was presented prior to exit.

Reference:

(1) "Multiple sclerosis (MS) is a nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells." 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=ms&_ga=2.53710894.747995928.1633538618-221748656.1633538618

3. The facility staff failed to administer oxygen to

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F 695	Continued From page 205 Resident #145 at the physician ordered rate. Resident #145 was admitted on 9/3/21 with the diagnoses of but not limited to COVID-19, respiratory failure, atrial fibrillation, and hypothyroidism. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 9/9/21. Resident #145 was code as being cognitively impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for bathing, hygiene, toileting, dressing, and bed mobility; and limited assistance for transfers and eating. On 9/28/21 at 12:53 PM, an observation of Resident #145 and the resident's oxygen was conducted. Resident #145 was observed receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen flow rate was set at 1 liter per minute, as evidenced by the flow meter ball set on the 1 liter line with the line positioned through the center of the flow meter ball. A review of the clinical record revealed a physician's order dated 9/4/21 for "Oxygen Therapy Oxygen at: 2 Liters/minute Via: NC (nasal cannula)." A review of the comprehensive care plan revealed one dated 9/13/21 for "Has/At risk for respiratory impairment related to covid 19, acute respiratory failure with hypoxia." This care plan included an intervention dated 9/13/21 for "Administer oxygen per physician order." On 10/4/21 at 2:30 PM, an interview was conducted with LPN #8 (Licensed Practical	F 695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 206 Nurse) the unit manager. When asked if the oxygen was set at 1 liter and the order was for 2 liters, was the oxygen being administered as ordered, LPN #8 stated it was not. A review of the facility manual for the oxygen concentrator documented on page 22, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liters per minute) line prescribed." A review of the facility policy, "Oxygen Administration" documented, "....Review the physician's orders or facility for oxygen administration...Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered...." On 10/4/21 at 5:00 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, was made aware of the findings. No further information was provided by the end of the survey. 4. The facility staff failed to ensure Resident #165's incentive spirometer was maintained in a sanitary manner. Resident #165 was admitted to the facility on 9/8/21 with the diagnoses of but not limited to atrial fibrillation, stroke, aphasia, dysphagia, high blood pressure, diabetes, and hypothyroidism. The Admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 9/16/21 coded Resident #165 as being cognitively impaired in ability to make daily life decisions.	F 695		

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The resident was coded as requiring extensive care for bathing, hygiene, toileting, and transfers; limited assistance for dressing and eating; and was incontinent of bowel and bladder.

On 9/28/21 at 12:50 PM, Resident #165 was observed up in his wheelchair in his room eating lunch. An uncovered incentive spirometer was observed on the overbed table.

On 9/29/21 at 8:45 AM, Resident #165 was observed in his wheelchair in his room. The incentive spirometer was still on the overbed table, uncovered. When asked if he uses the incentive spirometer, Resident #165 stated that he uses it sometimes.

A review of the clinical record revealed a physician's order dated 9/14/21 for "Incentive Spirometry Instruct Resident - Place the mouthpiece in your mouth, sealing your lips around it. Breathe in as slowly and deeply as possible. Try to raise the piston toward the top of the column and continue to hold for ~ (approximately) 3 seconds before exhaling. Cough between breaths. Perform 10 repetitions and 5 sets cough between sets."

On 10/4/21 at 2:30 PM, an interview was conducted with LPN #8 (Licensed Practical Nurse) the unit manager. When asked if an incentive spirometer should be covered when not in use, LPN #8 stated that it should be covered or in a bag.

A review of the facility policy for "Oxygen Administration and Therapeutics Topic: Incentive Spirometry" did not include directions regarding how to maintain the device in a sanitary manner

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F 695	Continued From page 208 when not in use. On 10/4/21 at 5:00 PM, ASM #1 (Administrative Staff Member) the Administrator, and ASM #2, the Director of Nursing, was made aware of the findings. No further information was provided by the end of the survey.	F 695		
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to implement a complete pain management program for one of 84 residents in the survey sample, Resident #153. The facility staff failed to attempt /provide non-pharmacological interventions prior to administering as needed pain medication to Resident #153 on multiple dates in August 2021 and September 2021. The findings include: Resident #153 was admitted to the facility with diagnoses that included but were not limited to bipolar disease (1), pressure ulcer of sacral region, stage 4 (2) and quadriplegia (3). Resident #153's most recent MDS (minimum data set), a	F 697	1. Resident #153 remains in center, new order for non-pharmacological interventions received. 2. All residents with prn pain medications ordered will receive pain management program to include non-pharmacological interventions 3. DON or designee will provide facility nursing staff with education on principles on non-pharmacological pain interventions prior to administration of prn pain medications. 4. DON or designee will audit 10% of all residents with prn pain medications to ensure provisions of non-pharmacological interventions were attempted prior to administration of pain medications weekly times 4 weeks and monthly times 2 to ensure that the facility is free of unnecessary medication administration. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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quarterly assessment with an ARD (assessment reference date) of 9/13/2021, coded Resident #153 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 J coded Resident #153 as receiving scheduled and as needed pain medications. Section J further coded Resident #153 as receiving non-pharmacological interventions for pain and as having pain frequently.

On 9/28/2021 at approximately 3:37 p.m., an interview was conducted with Resident #153. Resident #153 stated that they received pain medications often for chronic pain. When asked if staff attempted non-pharmacological interventions prior to administering the as needed pain medications, Resident #153 stated, "No, they give me a pill."

The comprehensive care plan for Resident #153 documented in part, "PAIN: [Resident #153] is at risk for increased pain re;lated [sic] to sacral wound & decline in health, Paralysis, limited ROM (range of motion) to Bilat (bilateral) LE (lower extremities) and LUE (left upper extremity) contracture and spasms, Neuropathy (4), Date Initiated: 02/11/2021, Revision on: 09/27/2021." Under "Interventions/Tasks" it documented in part, "Implement nondrug therapies such as diversional activity, biofreeze, rest, PROM (passive range of motion), ice/heat, etc to assist with pain and monitor for effectiveness Date Initiated: 03/30/2021..."

The physician orders for Resident #153 documented in part, "oxyCODONE HCl [hydrochloride] Tablet 10 MG (milligram)

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Controlled Drug Give 1 (one) tablet by mouth every 12 hours as needed for Pain related to CHRONIC PAIN SYNDROME. Order Date: 7/14/2021."

The eMAR (electronic medication administration record) dated 8/1/2021-8/31/2021 for Resident #153 documented administration of the as needed Oxycodone on the following dates/times:

- 8/3/21 at 3:00 a.m. and 3:03 p.m.
- 8/7/21 at 6:09 a.m.
- 8/9/21 at 3:14 p.m.
- 8/10/21 at 2:28 p.m.
- 8/11/21 at 2:16 a.m.
- 8/13/21 at 2:18 a.m.
- 8/15/21 at 2:17 a.m.
- 8/16/21 at 12:41 a.m. and 2:44 p.m.
- 8/17/21 at 3:11 a.m. and 3:13 p.m.
- 8/18/21 at 4:39 a.m. and 6:57 p.m.
- 8/19/21 at 1:56 p.m.
- 8/20/21 at 2:29 p.m.
- 8/21/21 at 2:56 p.m.
- 8/22/21 at 2:43 a.m. and 2:43 p.m.
- 8/25/21 at 2:40 a.m.
- 8/27/21 at 2:23 a.m. and 2:36 a.m.
- 8/30/21 at 3:06 p.m.
- 8/31/21 at 2:43 p.m.

The eMAR failed to evidence documentation of non-pharmacological interventions attempted prior to administration of the Oxycodone on these dates.

The eMAR dated 9/1/2021-9/30/2021 for Resident #153 documented administration of the as needed Oxycodone on the following dates/times:

- 9/2/21 at 2:10 a.m.
- 9/4/21 at 2:31 a.m. and 2:35 p.m.
- 9/8/21 at 2:30 a.m.

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- 9/9/21 at 2:35 a.m. and 3:20 p.m.
- 9/11/21 at 2:35 a.m.
- 9/12/21 at 2:33 a.m.
- 9/13/21 at 2:23 a.m.
- 9/14/21 at 2:29 a.m.
- 9/18/21 at 2:57 p.m.
- 9/21/21 at 2:30 a.m.
- 9/22/21 at 2:07 a.m.
- 9/23/21 at 2:46 a.m.
- 9/25/21 at 2:45 a.m. and 2:45 p.m.
- 9/26/21 at 2:25 a.m. and 2:46 p.m.
- 9/27/21 at 5:58 a.m.
- 9/28/21 at 2:30 a.m. and 2:39 a.m.

The eMAR failed to evidence documentation of non-pharmacological interventions attempted prior to administration of the Oxycodone on these dates.

The progress notes for Resident #153 failed to evidence documentation of non-pharmacological interventions attempted prior to administration of the Oxycodone on the dates listed above in August and September of 2021.

On 9/30/2021 at 7:09 a.m., an interview was conducted with LPN (licensed practical nurse) #13. LPN #13 stated that non-pharmacological interventions were attempted prior to administration of as needed pain medications. LPN #13 stated that they attempted things like repositioning the resident first and if that did not help then they administered the least strong of the as needed pain medications ordered for the resident. LPN #13 stated that the non-pharmacological interventions were attempted first because they may relieve the pain and prevent administration of unnecessary medications. LPN #13 stated that they documented the non-pharmacological

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interventions in a nurses note but was not sure what other staff did. LPN #13 stated that the non-pharmacological interventions should be documented to evidence that they were done.

On 9/30/2021 at 1:10 p.m., an interview was conducted with LPN #10, the unit nurse manager. LPN #10 stated that residents were asked to rate their pain and were offered non-pharmacological interventions prior to the administration of pain medications. LPN #10 stated that they repositioned residents and other non-pharmacological interventions to see if they relieved the pain to prevent unnecessary medications being administered. LPN #10 stated that the staff should document the non-pharmacological interventions attempted prior to the administration of the as needed pain medication on the medication administration record. LPN #10 stated that if the staff were not documenting the non-pharmacological interventions they could not evidence that they were completing them and they were not taking credit for the work they were doing.

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN #8. LPN #8 stated that residents were offered non-pharmacological interventions prior to administration of as needed pain medications. LPN #8 stated that residents were offered snacks, a quiet room or repositioning. LPN #8 stated that these were done because at times they relieved the pain without the use of the medication. LPN #8 stated that the non-pharmacological interventions were documented in the medical record in the progress notes. LPN #8 stated that if the non-pharmacological interventions were not documented in the medical record they could not

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evidence that they were attempted prior to the administration of as needed pain medications.

On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing, for the facility policy on pain management.

The facility policy "Pain Assessment and Management" dated March 2015 documented in part, "The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain...Non-pharmacological interventions may be appropriate alone or in conjunction with medications. Some non-pharmacological interventions include: a. Environmental - adjusting the room temperature, smoothing the linens, providing a pressure-reducing mattress, repositioning, etc.; b. Physical - ice packs, cool or warm compresses, baths, transcutaneous electrical nerve stimulation (TENS), massage, acupuncture, etc.; c. Exercise - range of motion exercises to prevent muscle stiffness and contractures; and d. Cognitive or Behavioral - relaxation, music, diversions, activities, etc...Implement the medication regimen as ordered, carefully documenting the results of the interventions...Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program..."

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing

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were made aware of the concern.

No further information was provided prior to exit.

References:

1. 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.

2. A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

3. Quadriplegia: "Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. Paralysis of the lower half of your body, including both legs, is called paraplegia. Paralysis of the arms and legs is quadriplegia." This information is taken from the website https://medlineplus.gov/paralysis.html.

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F 697	Continued From page 215 4. Neuropathy: Nerve damage. This information was obtained from the website: https://www.google.com/#q=neuropathy+nih <https://www.google.com/>.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to evidence ongoing communication and collaboration with the dialysis facility for one of 84 residents, Resident #110. The facility staff failed to evidence ongoing communication and collaboration with Resident #110's dialysis center. Multiple dialysis progress notes were incomplete and or missing in June 2021, July 2021, August 2021 and September 2021. The findings include: Resident #110 was admitted to the facility on 1/23/20. Resident #110's diagnoses included but were not limited to: diabetes mellitus (1), end stage renal disease (2) and schizophrenia. (3) Resident #110's most recent MDS (minimum data set) assessment, a quarterly assessment, with an	F 698	1. Resident #110 no longer in facility. 2. All residents receiving dialysis are at risk. Center reviewed all residents receiving dialysis services to ensure implementation of dialysis communication books with communication sheets for continuum of care. 3. DON or designee will provide facility nursing staff with policy regarding on going communication and use of communication books 4. DON or designee will audit 10% of all dialysis communication books to ensure completion of log in entirety weekly times 4 weeks and monthly times 2 to ensure that the facility maintains adequate continuum of care and coordination with dialysis centers. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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assessment reference date of 8/27/21, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded the resident as requiring limited assistance for mobility, transfers, walking, locomotion, dressing, bathing and hygiene. Section O-Special Treatments and Procedures: coded the resident as dialysis 'yes'.

A review of the comprehensive care plan dated 1/24/20 and revised 6/17/21, documented in part, "FOCUS: Renal insufficiency related to end-stage renal disease and required hemodialysis. INTERVENTION: Dialysis four times a week on Monday/Wednesday/Friday and Saturday."

A review of the physician orders dated 7/14/20, documented in part, "Hemodialysis Diagnosis: ESRD Dialysis Days: M-W-F-Sat. Pick up time: M-W-F pick up time 10am &Sat @ 7am to Dialysis Center."

A review of Resident #110's dialysis binder containing the "Dialysis Progress Note" with top section to be completed by the facility and the bottom portion to be completed by the dialysis center was completed. The records reviewed were from 6/1/21-9/28/21 and evidenced a total of 32 missing forms for the dates of: 6/17/21, 6/19/21, 6/22/21, 6/26/21, 6/29/21, 7/1/21, 7/3/21, 7/5/21, 7/7/21, 7/9/21, 7/12/21, 7/14/21, 7/16/21, 7/19/21, 7/21/21, 7/23/21, 7/26/21, 7/28/21, 7/30/21, 8/2/21, 8/4/21, 8/6/21, 8/9/21, 8/11/21, 8/13/21, 8/16/21, 8/17/21, 8/23/21, 8/25/21, 8/30/21, 9/13/21 and 9/15/21.

On 9/28/21 at 4:00 PM, an interview was

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conducted with Resident #110. When asked if she has a dialysis binder, Resident #110 stated, "Yes, it's right here. There are forms in there from here and the dialysis center."

On 9/28/21 at 6:30 PM the 32 missing dialysis communication forms for Resident #110 were requested from ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing.

On 9/28/21 at 6:30 PM, a request was made of ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing for the 32 missing dialysis communication forms for Resident #110.

On 9/29/21 at 8:30 AM, dialysis communication forms were provided for Resident #110 by ASM #2. In the group of dialysis communication forms labeled September 2021- a total of 13 forms with four of the 13 forms provided missing dates with none of these forms correlating to any of the missing dates listed above.
In the group of dialysis communication forms labeled August 2021- a total of 15 forms with 11 of the 15 forms provided missing dates with none of these forms correlating to any of the missing dates listed above
In the group of dialysis communication forms labeled July 2021- a total of one form was provided with one of one forms missing dates with this date not correlating to any of the missing dates listed above.
In the group of dialysis communication forms labeled June 2021- a total of 11 forms with five of the 11 forms provided missing dates with none of these forms correlating to any of the missing dates listed above.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING ______ B. WING ______	C 10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 698	Continued From page 218	F 698		

On 9/29/21 at 3:40 PM, ASM #2, the director of nursing stated, "Yes, the only dialysis communication forms we have for Resident #110 are the ones we provided. I know some of them don't have dates and we have no idea of what dates those forms were for."

On 9/30/21 at 10:00 AM, an interview was conducted with LPN (licensed practical nurse) #5. When asked the purpose of the dialysis progress note, LPN #5 stated, "It is to provide and receive communication from the dialysis center." When asked what information was to be provided, LPN #5 stated, "It is to provide vital signs, any medications for pain taken, and any issues with the graft or catheter site."

On 10/4/21 at 4:50 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

A review of the facility's "End-Stage Renal Disease, Care of a Resident with" revised 9/10, documented in part, "Includes all aspects of how the residents care will be managed including: how the care plan will be developed and implemented, how information will be exchanged between the facilities and responsibility for waste handling, sterilization and disinfection of equipment."

No further information was provided prior to exit.

References:
(1) Diabetes mellitus inability of insulin to function normally in the body. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th

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F 698	Continued From page 219 edition, Rothenberg and Chapman, page 160. (2) End stage of renal failure-inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 498. (3) Schizophrenia is mental disorder characterized by gross distortions of reality, withdrawal from social contacts and disturbances of thought, language, perception and emotional response. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 518.	F 698		
F 700 SS=D	Bedrails 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	F 700	1. Resident #127 is not currently residing in the center. Resident #67 remains in center and received education on risk/benefits of side rail use. 2. All residents with side rails in use reviewed to ensure risk/benefits have been discussed and reflected in documentation. 3. DON or designee will provide facility nursing staff with education on ensuring review and documentation of education on risk/benefits of side rail use.	

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F 700	Continued From page 220 and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to assess the risks and benefits of side rails for two of 84 residents in the survey sample, Resident #127 and Resident #67. The facility staff failed to evidence that the risks / benefits for the use of side rails had been reviewed with Resident #127 and Resident #67 prior to use of side rails. The findings include 1. The facility staff failed to evidence the risks / benefits for the use of side rails had been reviewed with Resident #127 prior to use. Resident #127 was admitted to the facility on 1/13/20. Resident #127's diagnoses included but were not limited to: diabetes mellitus (inability of insulin to function normally in the body) (1), chronic obstructive pulmonary disease 'COPD' (chronic and non-reversible lung disease) (2) and congestive heart failure 'CHF' (circulatory congestion and retention of salt/water by the kidneys) (3). Resident #127's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 9/3/21, coded the resident as scoring a 13 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded the resident as requiring supervision with bed	F 700	4. DON or designee will audit 10% of all residents to ascertain if side rails are in use and supporting documentation of education on risks/benefits was provided weekly times 4 weeks and monthly times 2 to ensure that the facility meets the guidelines for use of side rails. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 700	Continued From page 221	F 700		

mobility, transfers, dressing, personal hygiene, bathing, walking and locomotion; independent for eating. A review of MDS Section H- Bowel and Bladder: coded the resident as always continent for bowel and for bladder.

Resident #127 was observed in bed with bilateral side rails up on 9/29/21 at 8:00 AM, 9/30/21 at 7:45 AM and 10/4/21 at 8:00 AM.

A review of Resident #127's comprehensive care plan dated 4/30/20, documents in part, "FOCUS-ADL (activities of daily living) self-care deficit related to physical limitations from muscle weakness, easily fatigued and pain. INTERVENTIONS-Encourage to use assistive devices as able."

A review of the bed rail evaluation dated 9/1/20, documented in part, "Bed rail evaluation: #20. Bed rails will assist the patient by: improving balance, supporting self, exiting bed more safely, entering bed more safely, transferring more safely and providing sense of security. #22: check all that apply: a. Bed rail risks, benefits and precautions were discussed with the patient and/or patient representative and b. Alternatives to bed rails were discussed with the patient and/or patient representative." Box a. and box b. for #22 were unchecked and blank.

On 9/29/21 at 10:00 AM an interview was conducted with Resident #127. When asked if he used the bed rails, Resident #127 stated, "Yes, they help me to turn and reposition myself."

On 9/30/21 at 11:00 AM and interview was conducted with LPN (licensed practical nurse) #5. When asked the purpose of the bed rail

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evaluation, LPN #5 stated, "The purpose is to evaluate the resident's need for the bed rails, review the risks and benefits and obtain consent."

On 10/4/21 at 4:50 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

On 10/4/21 at 4:50 PM, ASM #2 stated, "I will look for the bed evaluations for Resident #127."

On 10/5/21 at 9:00 AM, ASM #2 stated, "There is no further information on bed rails."

The facility's "Bed Safety" policy dated 12/07, which documents in part, "Before using side rails for any reason, the staff shall inform the resident and family about the benefits and potential hazards associated with the side rails."

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 160.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 133.

2. The facility staff failed to evidence the risks / benefits for the use of side rails had been reviewed with Resident #67 prior to use.

Resident #67 was admitted to the facility on

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8/2/16. Resident #67's diagnoses included but were not limited to: paraplegia (paralysis of the lower limbs) (1), chronic obstructive pulmonary disease 'COPD' (chronic and non-reversible lung disease) (2) and osteoarthritis (most common form of arthritis characterized by degenerative changes in the joints) (3).

Resident #67's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/4/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. MDS Section G- Functional Status: coded the resident, as extensive assistance with bed mobility, transfers, dressing, locomotion, personal hygiene and bathing; walking did not occur. Eating was coded as independent. 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 in the up position on 9/28/21 at 2:00 PM, 9/29/21 at 9:00 AM and 9/30/21 at 9:55 AM.

A review of Resident #67's comprehensive care plan dated 1/9/20, documents in part, "FOCUS-At risk for falls/injuries due to generalized weakness, chronic fatigue and impaired mobility. INTERVENTIONS-Side rails at head of bed. Uses as enablers."

A review of the physician orders dated 5/15/19, documented in part, "1/2 side rails up in bed as enablers to turn and reposition due to weakness".

A review of the bed rail evaluation dated 9/21/20, documented in part, "Bed rail evaluation: #20.

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Bed rails will assist the patient by: improving balance, supporting self, exiting bed more safely, entering bed more safely, transferring more safely and providing sense of security. #22: check all that apply: a. Bed rail risks, benefits and precautions were discussed with the patient and/or patient representative and b. Alternatives to bed rails were discussed with the patient and/or patient representative." Box a. and box b. for #22 were unchecked.

On 9/29/21 at 9:00 AM, an interview was conducted with Resident #67. When asked if she used the bed rails, Resident #67 stated, "Yes, they help me to turn. Physical therapy is working with me on transferring and they stabilize me with during transfer."

On 9/30/21 at 11:00 AM and interview was conducted with LPN (licensed practical nurse) #5.. When asked the purpose of the bed rail evaluation, LPN #5 stated, "The purpose is to evaluate the resident's need for the bed rails, review the risks and benefits and obtain consent."

On 10/4/21 at 4:50 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above findings.

On 10/4/21 at 4:50 PM, ASM #2 stated, "I will look for the bed evaluations for Resident #67."

On 10/5/21 at 9:00 AM, ASM #2 stated, "There is no further information on bed rails."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the

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F 700	Continued From page 225 Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 432. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 120. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 420.	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review, it was determined the facility staff failed to document the annual training to include in dementia and abuse and neglect, for four of five CNA (certified nursing assistant), (CNA # 13, #14, #6 and #16). The findings include: The list of CNAs, employed greater than one year, was provided by ASM (administrative staff member) #1, the administrator, on 10/4/2021 at approximately 12:30 p.m. The list consisted of 38 CNA names and hire dates. Five CNA employee training records were reviewed, CNA #13, #14, #15, #6 and #16. A request was made for the annual performance	F 730	1. Employee #13, #14, #6, #16 and #15 provided mandatory 12-hour education 2. All current employees received mandatory 12 hours of training to include education on abuse/neglect and dementia care. 3. DON or designee will provide facility educator and HR on policy regarding mandatory annual education for CNA staff. 4. DON or designee will audit 10% of all staff to ensure acquisition of mandatory annual 12-hour competency weekly times 4 weeks and monthly times 2 to ensure that the facility maintains standards of necessary education. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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reviews and documentation of the required educations for CNAs to include abuse and dementia.

On 10/4/2021 at 4:17 p.m. RN (registered nurse) #3, the quality assurance and infection preventionist nurse, provided training documents from the following dates and the training that was performed:
4/29/2021 - dementia and Alzheimer's disease training
4/29/2021 - abuse and neglect training
6/10/2021 - abuse and neglect training
10/1/2021 - dementia training
10/2/2021 - abuse and neglect training.
RN #3 stated she did not have any file on CNA #16.

Review of the sign in sheets provided with each training failed to evidence that CNA #14, CNA #6 and CNA #16 attended any of these trainings. CNA # 13 had attended an abuse and neglect training on 6/17/2021.

An interview was conducted with RN #4, the staffing educator, on 10/5/2021 at 9:36 a.m. When asked to about the process followed for ensuring the staff receive the required educations, RN #4 stated she's been doing educations but unfortunately has not been timing them. When asked if they had a computer system that helps with education, RN #4 stated, "My understanding is we have a computer training system. I do not have access to it." When asked if the staff are giving assignments to complete in the computer system, RN #4 stated she had used the computer training program in her past job but since coming (to this facility) in March she has not been able to access it to assign the staff their

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F 730	Continued From page 227 training requirements. RN #4 stated, "We don't have all of mandatory trainings completed for all staff." A request was made for the policy on CNA training requirements on 10/5/2021 at 11:30 a.m. An email was received from ASM #2, the director of nursing, on 10/5/2021 at 3:10 p.m. that documented they do not have a policy related to mandatory training requirements for CNAs. The facility policy, "Abuse Prevention Program" documented in part, "4. Required staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management and handling verbally or physically aggressive resident behavior." ASM (administrative staff member) #2, the director of nursing, was made aware of the above concern on 10/5/2021 at 1:58 p.m.	F 730		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide medically related social services for three of 84 residents in the survey sample, (Residents #502, #40, and #91).	F 745	1. Resident #502 no longer resides in center. Residents #40 and #91 receive follow-up services and support as appropriate. 2. All residents involved in altercations since 09/01/2021 receive follow-up evaluation and support from facility social worker.	

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F 745	Continued From page 228 The facility staff failed to provide psychosocial follow up following Resident #502 being physically restrained on 5/6/21, failed to provide social services follow-up to Resident #40's request to be transferred to another facility and failed to provide social services follow-up following Resident #91's angry outburst, during which he fractured his hand by punching a hole in his wall. The findings include: 1. The facility staff failed to provide psychosocial follow up following Resident #502 being physically restrained on 5/6/21. Resident #502 was admitted to the facility on 4/27/16, and most recently readmitted on 12/9/20, with diagnoses including dementia with behaviors and arthritis. She was discharged from the facility on 6/12/21. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/21, Resident #502 was coded as being severely cognitively impaired for making daily decisions, having scored one out of 15 on the BIMS (brief interview for mental status). She was coded as not being placed in physical restraints during the look back period. A review of Resident #502's clinical record revealed the following progress note, dated 5/6/21: "[Resident #502] was observed with wristband attached to the arm rail of her bed via article of clothing. The wristband was removed and a skin assessment was completed. No integrity issues noted." A review of the final FRI (facility reported incident)	F 745	3. DON or designee will provide facility social worker with education regarding follow-up care and services following reportable incidents or altercations. 4. DON or designee will audit 10% of all resident altercations or facility reportable incidents to ensure social services is providing follow-up and ongoing support weekly times 4 weeks and monthly times 2 to ensure that the facility maintains the psychosocial well-being and support of residents. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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submitted by the facility to the state agency on 5/11/21 revealed, in part: "On [5/6/21], staff observed [Resident #502]'s wristband was attached to the bedrail via a string-like material. Investigation findings: [Resident #502] noted to be without injury. All residents on unit interviewed to ascertain feelings of safety, all reported no area of concern. All residents on unit assessed for signs of injury, non-observed. Psychosocial well-being will continue to be followed up on by Social Worker."

Further review of Resident #502's clinical record revealed no evidence of a psychosocial follow up by the social worker.

A review of Resident #502's comprehensive care plan dated 5/11/16 and updated 6/26/16 revealed, in part: "At risk for changes in mood related to diagnosis of dementia, atypical psychosis ...Assess for physical/environmental changes that may precipitate change in mood." The review revealed no update regarding the resident being placed in physical restraints.

On 9/30/21 at 10:27 a.m., ASM (administrative staff member) #4, the medical director, was interviewed. ASM #4 stated he knew Resident #502 for many years. He stated he was not familiar with the circumstances regarding Resident #502's being tied to her bed, but he believed a nurse and perhaps a supervisor were terminated as a result.

On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. OSM #4 stated she could not speak to anything that was

F 745 Continued From page 230 F 745

or was not done prior to her arrival at the facility. When asked if the social worker should perform a psychosocial assessment of a resident following an incident in which the resident was tied to her bed by her wrist, OSM #4 stated, "Absolutely. No question."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked if a social services psychosocial assessment had been performed on Resident #502 following the incident in which she was tied to her bed, ASM #2 stated, "There was none." When asked if this should have been done, ASM #2 stated, "Yes. Of course."

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. When asked about the social worker's role in psychosocial assessments for residents, he stated the social worker is responsible for going to interview the resident and see if any new interventions need to be put in place following any sort of unusual event. He stated the social worker should have followed up following Resident #502's being tied to her bed.

A review of the facility document, "Social Worker Job Description," revealed, in part: "Performs resident/family evaluations and histories. Provides psychosocial support through individual, group, or family counseling, as needs dictate. Continuously reviews service area for group support needs and opportunities."

No further information was provided prior to exit.

Complaint Deficiency

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2. The facility staff failed to provide social services follow-up to Resident #40's request to be transferred to another facility.

Resident #40 was admitted to the facility on 11/28/19 with diagnoses including multiple sclerosis, a brain injury, and drug abuse. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/16/21,
Resident #40 was coded as having no cognitive impairment for making daily decisions, having scored 13 out of 15 on the BIMS (brief interview for mental status).

On 9/28/21 at approximately 10:00 a.m., Resident #40 was observed standing on the sidewalk in front of the facility. He was unsupervised by staff, and he was smoking.

On 9/29/21 at 10:10 a.m., Resident #40 was interviewed. He stated after the observation on 9/28/21 of him standing on the sidewalk smoking, ASM (administrative staff member) #1, the administrator, took his cigarettes. He stated he wants to move to a different facility, and the administrator is working on the transfer.

A review of Resident #40's clinical record revealed the following progress notes:

"7/22/2021 11:42 (11:42 a.m.) Social Services Note Text: SW (social worker) and Administrator met with resident on this date. Resident requested for alternate options for placement with other individuals of his age, smoking, and medical status. SW will follow-up with his mother per his request. Resident requested for his information be faxed to [name of facility]. Referral

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has been emailed to [name of admissions coordinator at local facility]."

"7/29/2021 11:33 (11:33 a.m.) Social Services Late Entry: Note Text: Meeting held with writer, resident, RP (responsible party), administrator and Ombudsman...to discuss resident's long term plans. Discussed resident's physical and psychosocial needs as well as the appropriate placement to meet said needs. Resident stressed he would like to explore living options outside of the facility. All parties agreeable to referrals being sent to several facilities in the area. Referrals to be sent to [names of four local facilities]. Will continue to assist in facilitating transfer and will continue to follow and assist with needs as they arise." [Note: The staff member who wrote these two notes no longer works at the facility.]

Further review of Resident #40's clinical record revealed no evidence of further follow-up by the social worker.

A review of Resident #40's comprehensive care plan dated 11/27/20 revealed, in part: "Patient does not show potential for discharge to the community due to physical care needs...Provide referrals to area centers upon request...Reassess care needs and potential for discharge as needed."

On 10/4/21 at 5:06 p.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. ASM #1 stated when he arrived at the facility within the last three months, he began enforcing the no smoking policy. He stated as a result, Resident #40 requested a transfer to a facility where he would be able to smoke. ASM #1 stated he met with the

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F 745	Continued From page 233 social worker and the resident's mother. He stated the resident and his mother agreed to a facility, then changed their minds. ASM #1 stated, "I am still going through that process to get them to agree on a facility." He stated he is working on a group home placement for the resident. When asked about any efforts since 7/29/21, he stated he had evidence of ongoing conversations and facility efforts, and would provide those to the survey team. Prior to exit, ASM #1 did not provide any additional information regarding follow-up on alternate placement for Resident #40. A review of the facility document, "Social Worker Job Description," revealed, in part: "Works with the resident, family, and other members of the health care team to formulate a discharge plan that provides the resident services in the appropriate post-acute care setting. Gathers and assesses information regarding the resident's physical needs, mental status, family support system, financial resources, and available community and governmental resources. Employs assessment to develop a comprehensive case management plan that will address the needs identified. Determines specific objectives, goals, and measures that are designed to meet the client's needs that have been identified through assessment. The plan will be action- oriented and time-specific including collaboration with utilization management to manage length of stay. Maintains contact with the resident's third-party payers to ensure the most cost-effective plan of care is being carried out and appropriate in network providers are being utilized. Provides information about resources and options available in the community and coordinates service delivery. Interprets resident/family needs	F 745		

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and provides information concerning the availability and limitations of resources. Educates and addresses concerns with service delivery including service gaps and access issues. Implements discharge plan through service referral and coordination activities."

No further information was provided prior to exit.

Complaint Deficiency

3. The facility staff failed to provide social services follow-up following Resident #91's angry outburst, during which he fractured his hand by punching a hole in his wall.

Resident #91 was admitted to the facility on 12/15/20, and most recently readmitted on 8/10/21, with diagnoses including diabetes and right leg amputation. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 8/17/21, the resident was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of Resident #91's clinical record revealed the following note dated 6/21/21: "Resident alert and verbal, observed to be angry at the beginning of the shift. Resident was witnessed punching his left hand on the wall out of anger. Resident complains of left hand swelling, pain, and discomfort on ROM (range of motion."

Further review of Resident #91's clinical record revealed an X-ray performed on 6/21/21 confirmed Resident #91's left hand was broken.

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Further review of Resident #91's clinical record revealed no evidence of social services follow-up after the 6/21/21 incident.

A review of Resident #91's comprehensive care plan dated 12/24/20 and updated 8/27/21 failed to reveal information related to the 6/21/21 incident.

On 10/4/21 at 10:34 a.m., OSM (other staff member) #4, the director of social services, was interviewed. She stated she had only been working at the facility for three days. She stated she could not speak to anything that was or was not done prior to her arrival at the facility. When asked if the social worker should perform a psychosocial assessment of a resident following an incident in which the resident broke his hand by punching his wall following an angry outburst, OSM #4 stated, "Yes."

On 10/4/21 at 3:39 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked if a social services psychosocial assessment had been performed on Resident #91 following the incident in which he fractured his hand by punching a wall, she stated: "There was none." When asked if this should have been done, ASM #2 stated, "Yes."

On 10/4/21 at 5:06 p.m., ASM #1, the administrator, was informed of these concerns. When asked about the social worker's role in psychosocial assessments for residents, he stated the social worker is responsible for going to interview the resident and see if any new interventions need to be put in place following any sort of unusual event. He stated the social worker should have followed up following Resident #91's

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F 745	Continued From page 236 angry outburst and hand fracture. No further information was provided prior to exit. Complaint Deficiency	F 745		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility staff failed had expired medications and IV (intravenous) fluids that were	F 761	1. The facility discarded all expired intravenous medications from the medication room and all expired medications from the medication carts. 2. All medication rooms and medication carts were inspected to ensure no expired medications remained for possible use. 3. DON or designee will provide education to facility nursing staff on policy for medication storage to include handling of expired medications. 4. DON or designee will audit all medication rooms and medication carts to ascertain that there are no expired medications or multidose bottle medications available for use and that these medications are discarded according to the manufacturer's suggested date of disposal, weekly times 4 weeks and monthly times 2 to ensure that the facility is in accordance with expiration dates as applicable. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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F 761	Continued From page 237 available for use in one of two medication rooms and one of four medication carts, Wing Two medication room and Wing Two front hall medication cart. In the Wing two medication room, three bags of IV solution, Dextrose 5% with .9%Normal Saline were observed available for resident use. Two of the bags expired "Sep (September) 2021" and one bag documented the expiration date of "Aug 2021." In the front hall medication cart for Wing two on 10/5/2021, a bottle of Aspirin 325 mg (milligrams) was opened on 2/4/2021 and available for resident use. The expiration date on the bottle documented, "expired 7/2021." A bottle of One Daily Multivitamin was open, available for resident use and had an expiration date documented on the bottle that read, "Best by: 11/20." The findings include: Observation was made of the mediation room on Wing two on 10/5/2021 at 8:15 a.m. There were three bags of IV solution, Dextrose 5% with .9%Normal Saline. Each bag was 1000 cc (cubic centimeters). Two of the bags expired "Sep (September) 2021" and one bag documented the expiration date of "Aug 2021." An interview was conducted with LPN (licensed practical nurse) #8, the unit manager, on 10/5/2021 at 8:26 a.m. The bags of IV fluids were reviewed with LPN #8. When asked if the bags were available for use, LPN #8 stated, yes. When asked if the resident that these were intended for was still a resident in the facility, LPN #8 stated the resident was discharged.	F 761		

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F 761	Continued From page 238 Observation was made of the front hall medication cart for Wing two on 10/5/2021 at 8:55 a.m. A bottle of Aspirin 325 mg (milligrams) was opened on 2/4/2021. The expiration date on the bottle documented, "expired 7/2021." The bottle was three quarters full. A bottle of One Daily Multivitamin was open and had an expiration date documented on the bottle that read, "Best by: 11/20." An interview was conducted with LPN #19 on 10/5/2021 at 9:00 a.m. LPN #18 was asked to look at the bottles above. When asked if these medications were available for use, LPN #18 stated, yes. When asked the process for administering mediations, LPN #18 stated you have to check for the right dose, right patient, right time and right medication. When asked if the expiration date should be checked, LPN #18 stated, "Yes." A copy of the facility policy related to the storage of medications and IV fluids was requested on 10/5/2021 at 11:30 a.m. ASM (administrative staff member) #2, the director of nursing, was made aware of the above concern on 10/5/2021 at 1:58 p.m. ASM #2 stated in an email dated 10/5/2021 at 3:10 p.m. that the facility did not have a policy on the storage of medications and IV fluids that were expired. No further information was provided prior to exit.	F 761		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services.	F 770		

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F 770	Continued From page 239 §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to provide timely laboratory services for one of 84 residents in the survey sample, Resident #13 and failed to ensure laboratory supplies past their expiration date were not available for use in one of two medication rooms observed, Wing two medication room. 1. The facility staff failed to ensure timely results of an ordered urinalysis for urinary tract infection symptoms for Resident #13. Resident #13 complained of concerns of a urinary tract infection with a urinalysis ordered on 9/26/2021, collected on 9/28/2021 and results still pending from laboratory on 10/4/2021 when discussed with facility staff. 2. A box of Hemoccult slides (1), approximately half full, with an expiration date of 1/31/2021, was found available for resident use in the Wing two medication room. The findings include: 1. Resident #13 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (1) and	F 770	1. Resident #13 still resides in the facility, results were received and provided to MD for recommendations during inspection. 2. All residents receiving laboratory studies are at risk. 3. DON or designee will ensure timely follow up on laboratory results and that expiration dates on supplies for in-house provided laboratory services are discarded by manufacturers suggestion date of disposal. 4. DON or designee will audit 10% of All labs ordered to ascertain that the results are reported in a timely manner and that all in-house lab supplies are not expired according to the manufacturer's suggested date of disposal, weekly times 4 weeks and monthly times 2 to ensure that the facility provides timeliness of laboratory services and that the in-house provided laboratory services meet applicable requirements. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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personal history of urinary tract infections (2). Resident #13's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/1/2021, coded Resident #13 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section H coded Resident #13 as being frequently incontinent of urine.

On 9/28/2021 at approximately 2:00 p.m., an interview was conducted with Resident #13. Resident #13 stated that they currently had a urinary tract infection. Resident #13 stated that they were not being treated for the infection because they were waiting for the results of the urine specimen to come back from the lab [laboratory]. Resident #13 stated that there was always a delay in getting their results of any testing done at the facility and they were not sure of what the problem was.

On 10/4/2021 at approximately 2:30 p.m., a follow up interview was conducted with Resident #13. Resident #13 stated that they had not gotten any results from the urine sample sent to the lab the previous week and they felt like they still had a urinary tract infection because they had burning when urinating. Resident #13 stated that they hoped the results would come back that day.

The physician orders for Resident #13 documented in part, "UA/C&S (urinalysis with culture and sensitivity) for UTI (urinary tract infection) MAY STRAIGHT CATH (catheterize) RESIDENT one time only for 1 Day. Order Date: 9/26/2021."

The progress notes for Resident #13 documented

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F 770	Continued From page 241 in part, "9/25/2021 17:37 (5:37 p.m.) Physician/Practitioner Progress note...She also had complaints of urinary urgency and frequency. An order was written for a straight cath UA collected tomorrow and to send for urinalysis and culture..." "9/26/2021 15:15 (3:15 p.m.) Nursing/Clinical. Note Text: Order to collect urine via (by) straight cath [catheter] fro [sic] UTI." "9/27/2021 07:31 (7:31 a.m.) Nursing/Clinical. Note Text: unable to collect urine via straight cath as resident has white thick discharge in vaginal area. Resident was also so tense during procedure, nurse and staff unable to obtain a sterile straight cath." "9/28/2021 07:54 (7:54 a.m.) Nursing/Clinical. Note Text: LATE ENTRY 9/27/21: Resident urine collected today resident stated she has be having some burning when voiding resident results currently pending will follow up with Md (medical doctor) on reschedule." "9/29/2021 14:06 (2:06 p.m.) Physician/Practitioner Progress Note...GU (genitourinary): + (positive) urinary pressure, urinary freq (frequency)..." "9/29/2021 19:05 (7:05 p.m.) Nursing/Clinical...UA/C&S results pending." "9/30/2021 20:56 (8:56 p.m.) Nursing/Clinical...UA/C&S results pending." "10/4/2021 20:03 (8:03 p.m.) Nursing/Clinical. Note Text: Contacted [Name of laboratory] and [Name of laboratory] in regards to urine sample sent off for testing, the labs were unable to locate the sample. NP (nurse practitioner) [Name of NP] notified of this matter. NP was also aware the resident states that the discomfort is not predominantly as it was at first but manageable. She is tolerating fluids well. See changes made to	F 770	RECEIVED NOV 29 2021 VDH/OLC	

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POC (plan of care) per NP [Name of NP]. Resident notified of said changes & pleased with them."

On 10/4/2021 at 11:36 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that urinalysis specimens were collected on the night shift in the morning. LPN #8 stated that they had two lab companies that they used for testing. LPN #8 stated that the lab that Resident #13's urine specimen went to was located out of state. LPN #8 stated that they collected the specimen and the nurse supervisor took the specimen to the [Name of delivery service] box the same day to ship it to the lab. LPN #8 stated that they were not sure of the time frame for delivery to the lab.

On 10/4/2021 at 3:06 p.m., an interview was conducted with LPN #10, the unit nurse manager. LPN #10 stated that they had two lab companies they used for testing. LPN #10 stated that the facility preferred them to use the lab that was out of state that Resident #13's urine specimen was sent to. LPN #10 stated that they were not sure why. LPN #13 stated that it was very difficult to get results from the out of state lab because they did not post any results onto the website until the specimen was completed. LPN #10 stated that there was only one log in for the entire facility to share and it was very difficult to maneuver the website to obtain results. LPN #10 stated that the other lab company was much easier to work with and get results back timely. LPN #10 stated that collected the specimens and mailed them to the lab by [Name of delivery service] and that there was normally a wait to get results of the testing. LPN #10 stated that Resident #13's urinalysis was still pending and they had not received any

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results at that point. LPN #10 stated that they would contact the lab to check the status of the specimen sent out on 9/28/2021.

On 10/5/2021 at approximately 9:15 a.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the facility policy on laboratory services.

The facility policy "Availability of Services, Diagnostic" dated December 2009 documented in part, "Clinical laboratory and radiology services to meet the needs of our residents are provided by our facility...Our facility does not provide on-premises diagnostic services. Only the following tests may be conducted by the facility. All others are forwarded to the lab service specified by facility policy.
a. Routine urinalysis...

On 10/4/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the concern.

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. Urinary tract infection: The urinary system is the body's drainage system for removing wastes and extra water. It includes two kidneys, two ureters, a bladder, and a urethra. Urinary tract

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infections (UTIs) are the second most common type of infection in the body. 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=urinary+tract+infectio n

2. Observation was made of the medication room on Wing two on 10/5/2021 at 8:15 a.m. A box of Hemoccult slides (1), approximately half full, was found with an expiration date of 1/31/2021.

An interview was conducted with LPN (licensed practical nurse) #8, the unit manager; on 10/5/2021 at 8:26 a.m., LPN #8 was asked to review the box of Hemoccult slides. When asked if the slides were expired, LPN #8 stated, yes. When asked if they were available for use, LPN #8 stated, "Yes."

According to applicable requirements for laboratories specified in Part 493 of this chapter: § 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies.(4) (d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality.

ASM (administrative staff member) #2, the director of nursing, was made aware of the above findings on 10/5/2021 at 1:58 p.m.

No further information was provided prior to exit.

References:

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F 770	Continued From page 245 (1) Tests for fecal occult blood detect blood in the stool that is not visible on gross inspection, usually less than 50 mg of hemoglobin per gram of stool. this information was obtained from the website:https://www.ncbi.nlm.nih.gov/books/NBK 445/	F 770		
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 staff interview and facility document review, it was determined the facility staff failed maintain food in a safe and sanitary manner. A gallon of whole milk unopened with an expiration date of 9/24/21 and one-half of a gallon of whole milk with an expiration date of 9/24/21 were found in the refrigerator.	F 812	1. Facility discarded all milk with the expiration date of 9/24/2021. 2. All residents are at risk. 3. DON or designee will ensure that expiration dates for all food items are discarded by manufacturers suggestion date of disposal. 4. DON or designee will audit all refrigerated items to ascertain that the product is not expired according to the manufacturer's suggested date of disposal, weekly times 4 weeks and monthly times 2 to ensure that the facility maintains and stores food in accordance with professional standards for food service safety. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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The findings include:

On 9/28/21 at 10:55 AM, an observation was conducted in the main kitchen. In the refrigerator a gallon of whole milk unopened with an expiration date of 9/24/21 and one-half of a gallon of whole milk with an expiration date of 9/24/21 were found.

An interview was conducted on 9/28/21 at 11:10 AM with OSM (other staff member) #1, the chef. When asked the expiration for milk, OSM #1 stated, "Yes, the opened whole milk with best by date of 9/24/21 will get discarded on 9/30/21. If it were an unopened gallon with date of 9/24/21, I would discard it now." When OSM #1, was shown the gallon of whole milk unopened with date of 9/24/21. OSM #1 stated, "I'll discard this now".

An interview was conducted on 9/28/21 at 11:40 AM with OSM #2, the dietary manager. When asked about the expiration for the one half gallon of whole milk with a date of 9/24/21, OSM #2 stated, "No, it should be discarded. I will do it now."

On 9/28/21 at 12:30 PM, OSM #2 provided the facility's "Food Receiving and Storage" policy dated 10/17.

The facility's "Food Receiving and Storage" policy dated 10/17, which documents in part, "All foods stored in the refrigerator will be covered, labeled and dated ('use by' date).

On 10/4/21 at 4:50 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the

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F 812	Continued From page 247 director of nursing were made aware of the above findings. No further information was provided prior to exit.	F 812		
F 840 SS=E	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to have a written dialysis agreement for the facility. The facility failed to have current written contracts with two dialysis companies being utilized for residents. The facility failed to ensure new contracts were obtained when undergoing a CHOW (change of ownership) in January 2020.	F 840	1. Facility obtained active contract with Dialysis provider. 2. All Dialysis residents are at risk. 3. DON or designee will ensure that dialysis contracts will be maintained in facility. 4. DON or designee will audit 10% of dialysis residents to ascertain that there is a contract with the dialysis provider from which they receive services, weekly times 4 weeks and monthly times 2 to ensure that the facility maintains current written contracts with dialysis companies being utilized by residents: Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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The findings include:

During the entrance conference to the facility on 9/28/21, a request was made for the dialysis contracts or agreements to be provided.

On 9/29/21, a review of the dialysis contracts evidenced contracts dated 2009 and 2013 for the one dialysis company.

On 10/4/21 at approximately 1:30 PM, ASM (administrative staff member) #1, the administrator, brought in requested documents including the facility policy "End-Stage Renal Disease, Care of a Resident with" no date on policy. There was an attached sticky note to the policy documenting "Verbal agreement for dialysis".

On 10/4/21 at 1:51 PM ASM #1, the administrator, brought papers to the survey team and stated, ""We have a verbal agreement with the dialysis companies. When this facility was bought in January 2020, there have not been new contracts signed. I have talked with the corporate office and they are aware and are working on this. This was before I came. I came in July 2021."

On 10/4/21 at 4:30 PM, during the end of day conference, when asked to verify that only verbal agreements were in place with the facility and two dialysis companies, ASM #1, the administrator, stated, "Yes that is correct."

On 10/5/21 at 10:15 AM, ASM #2 provided a contract dated 9/2016 for the second dialysis company.

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F 840	Continued From page 249 A request was made on 10/5/21 at approximately 9:00 AM for any policy regarding facility contracts with outside resources, none was provided. On 10/4/21 at 4:50 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the above findings. No further information was provided prior to exit.	F 840		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §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	F 842	1. Residents #111 and #158 remain in the facility and are a member of PACE services. Physician's documentation was obtained and added to their medical records. 2. All PACE residents are at risk. The Center coordinated with PACE providers to obtain documentation missing from medical records. 3. DON or designee will educate all PACE providers that progress notes should be Included in the chart at the time of each visit. 4. DON or designee will audit 10% of PACE residents to ascertain that progress notes are included in the medical chart weekly times 4 weeks and monthly times 2 to ensure that the facility maintains a complete, accurately documented, readily accessible and systematically organized medical record. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be	11/19/21

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representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches 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.

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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 maintain a complete clinical record for two of 84 residents in the survey sample, Residents #111 and #158.

The facility staff failed to maintain a physician's note in Resident #111's and Resident #158's clinical records.

The findings include:

1. Resident #111 was admitted to the facility on 5/24/21. Resident #111's diagnoses included but were not limited to diabetes, dementia and anxiety disorder. Resident #111's quarterly minimum data set assessment with an assessment reference date of 8/28/21, coded the resident's cognition as severely impaired.

Review of Resident #111's clinical record revealed a nurse's note dated 9/6/21 that documented the resident was transferred to the hospital due to a fall.

Further review of Resident #111's clinical record failed to reveal physician documentation regarding Resident #111's hospital transfer.

On 9/30/21 at approximately 8:00 a.m., ASM (administrative staff member) #2 (the director of nursing) provided a physician's note dated 9/6/21 regarding Resident #111's hospital transfer. The note was attached to an email from the physician to ASM #2 and was dated 9/29/21.

On 10/4/21 at 10:22 a.m., an interview was

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conducted with ASM #2. ASM #2 stated the physician note dated 9/6/21 was not in Resident #111's clinical record. ASM #2 stated she had to reach out to the physician to obtain the note that was kept in a file in her facility.

On 10/4/21 at 11:25 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 policy titled, "Clinical Records Policy & Procedure" documented, "4. An accurate and complete clinical record shall be maintained for each resident and shall include: e. Progress notes written at the time of each visit..."

No further information was presented prior to exit.

2. Resident #158 was admitted to the facility on 7/14/20. Resident #158's diagnoses included but were not limited to dementia, diabetes and muscle weakness. Resident #158's quarterly minimum data set assessment with an assessment reference date of 9/26/21, coded the resident's cognition as severely impaired.

Review of Resident #158's clinical record revealed the resident was transferred to the hospital on 9/3/21 due to abdominal pain.

Further review of Resident #158's clinical record failed to reveal physician documentation regarding Resident #158's hospital transfer.

On 9/30/21 at approximately 8:00 a.m., ASM (administrative staff member) #2 (the director of nursing) provided a physician's note dated 9/3/21 regarding Resident #158's hospital transfer. The

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F 842	Continued From page 253 note was attached to an email from the physician to ASM #2 and was dated 9/29/21. On 10/4/21 at 10:22 a.m., an interview was conducted with ASM #2. ASM #2 stated the physician note dated 9/3/21 was not in Resident #158's clinical record. ASM #2 stated she had to reach out to the physician to obtain the note that was kept in a file in her facility. On 10/4/21 at 11:25 a.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 842		

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