STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BRIAN CENTER HEALTH AND REHABILITATION	188 OLD FINCASTLE ROAD FINCASTLE, VA 24090

(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 3/2/21 through 3/4/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/02/21 through 3/04/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 56 certified bed facility was 47 at the time of the survey. The survey sample consisted of 12 current Resident reviews and 3 closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review, and facility document review, the facility	F 607	F 607	4/18/21

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

Electronically Signed | 04/07/2021

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F 607	Continued From page 1 staff failed to implement their policy related to preventing abuse, neglect and exploitation in regards to new hires for 1 of 15 new hires, (RN) registered nurse #1. The findings included: The facility failed to ensure the contracting company obtained a (VSP) Virginia State Police criminal background check as required by Code of Virginia 32.1-126.01 for RN #1 and failed to obtain a sworn statement. The facility policy titled, "Abuse" dated 11/28/2016 read in part, "...Criminal record checks will be obtained in accordance with state law and/or facility policy...Each applicant will provide a sworn statement or affirmation disclosing any criminal convictions or any pending criminal charges...Criminal record checks will be obtained on all new employees within 30 days of date of hire. If contract staff is used...the vendor providing the contracted service will be asked to obtain criminal record checks for all staff assigned to the nursing facility and to make the criminal record check information available to the nursing facility in a timely manner upon request...The facility will obtain an original criminal history record from the Central Criminal Records Exchange with the State Police as defined in the Code of Virginia 32.1-126.01..." RN #1 had a hire date of 11/03/20. During the employee record review the surveyor was unable to locate a VSP background check or a sworn statement for this employee. On 03/03/21 at 4:40 p.m., the chief nursing officer, regional nurse consultant, interim (DON)	F 607	A VSP background check for RN #1 was completed and shared with surveyor on 3/4/21, showing no identifiable records. A review of new hires for the last 3 months was completed to ensure VSP criminal background checks and sworn statements were accounted for. The Human Resources Coordinator was educated by the Corporate Director of Human Resources/designee on the requirements for new hires including obtaining VSP criminal background checks and sworn statements. The Chief Administrative Officer (CAO)/designee will review new hire personnel files at the time of hire to ensure new hire paperwork has been completed including criminal background checks and sworn statements. The results will be reported to the monthly Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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F 607	Continued From page 2 director of nursing, administrator, and regional (HR) human resource personnel #1 were made aware of the missing documentation. The regional HR stated they would reach out to the agency. On 03/04/2021 at 2:40 p.m., the regional HR stated a VSP background check was completed today and shared the results with the surveyor this document read no identifiable records. The regional HR stated they were unable to obtain a sworn statement from the agency. § 32.1-126.01 Code of Virginia-Any person desiring to work at a licensed nursing home shall provide the hiring facility with a sworn statement or affirmation disclosing any criminal convictions. A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange from the Virginia State Police. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 607		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		4/18/21

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F 684	Continued From page 3 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure that residents receive treatment and care in accordance with the comprehensive person-centered care plan as evidenced by failure to follow physician's orders for 1 of 15 residents, Resident # 35. The findings included: For Resident #35, the facility staff failed to follow physician's orders for the administration of Digoxin (medication used to treat heart failure and abnormal heart rhythms) and failed to administer treatments to the resident's right buttock and left lower leg as ordered. Resident #35's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure with Hypercapnia, Chronic Diastolic (Congestive) Heart Failure, Pulmonary Hypertension Unspecified, Paroxysmal Atrial Fibrillation, Quadriplegia Unspecified, Dependence on Respirator (Ventilator) Status, and Peripheral Vascular Disease Unspecified. The significant change MDS (minimum data set) with an ARD (assessment reference date) of 1/15/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns. Resident #35 was coded for the presence of 2 venous and arterial ulcers and MASD (moisture associated skin damage) in section M, Skin Conditions. A review of Resident #35's clinical record	F 684	F684 Resident #35 is receiving Digoxin as per MD orders including holding medication if the B/P is outside the parameters. Resident #35 is receiving wound care to the wound on the right buttock and left lower leg as per MD order. An audit for the last 30 day was conducted for residents receiving the medication Digoxin and wound care to ensure the medication and wound care was being provided to residents based on current MD orders. Licensed nurses will be educated by the Director of Nursing/designee on following MD orders including those orders with parameters on when to hold medications. In addition, education also included following MD orders for wound care and documentation on the electronic treatment administration record. Director of Nursing/designee will review EMAR and ETAR reports 5x weekly daily in clinical meeting to ensure hold parameters of medications are adhered to and wound care treatments are completed per MD orders. The results will be reported to the monthly to the Quality Assurance Committee for	

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F 684	Continued From page 4 revealed an active physician's order dated 2/04/21 stating "Digoxin Tablet 250 MCG Give 1 tablet by mouth one time a day for Afib (atrial fibrillation) Hold for SBP (systolic blood pressure) <100 or HR (heart rate) <60". Surveyor reviewed Resident #35's February 2021 MAR (medication administration record) which included documentation on 2/19/21 at 8:00 am that the resident's blood pressure was 94/52 and Digoxin was administered. Resident #35's current care plan includes a focus area of "resident is at risk for digoxin toxicity and cardiac arrhythmias related to digoxin use secondary to: A Fib" with an intervention to "administer meds as ordered". Resident #35's February 2021 TAR (treatment administration record) included an order with a start date of 2/10/21 and a d/c date of 2/18/21 to "Cleanse MASD to right buttock with ns (normal saline), pat dry, apply santyl and cover with dry dressing Q (every) day and PRN (as needed) every day shift" and an order with a start date of 2/10/21 and a d/c date of 2/18/21 to "Cleanse pressure injury to left lower leg with ns, pat dry, apply santyl and mupirocin ointment, cover with dry dressing Q day and PRN". According to the February 2021 TAR, the treatments to the right buttock and the left lower leg were not administered as ordered by the physician on 2/12/21, 2/15/21, and 2/18/21. A "Wound Rounds" note dated 2/04/21 4:17 pm described the area to Resident #35's left lower leg as a "venous wound" to the "left lateral shin". Resident #35's current care plan includes a goal	F 684	review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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F 684	Continued From page 5	F 684		

initiated on 2/12/21 stating in part, "MASD to right buttock will resolve without complications x 30 days" with an intervention to provide "treatments as ordered". Resident #35's care plan also includes a focus area stating in part, "Venous stasis ulcer dx (diagnosis) PVD (peripheral vascular disease) Left lower leg (lateral shin)" with an intervention stating "Treatment as ordered: see TAR".

A "(name omitted) Wound Physicians Wound Care Telemedicine Follow Up Evaluation" report dated 2/18/21 described the wound to Resident #35's right buttock as measuring 10 x 6.5 x not measurable cm with moderate serous exudate with 70% thick adherent devitalized necrotic tissue, 30% skin and deteriorated wound progress due to generalized resident decline. The wound on Resident #35's left lower leg is described as a venous wound measuring 4 x 2 x not measurable cm with moderate sero-sanguinous exudate with 70% thick adherent devitalized necrotic tissue and 30% granulation tissue. The wound progress is also noted as deteriorated due to the generalized decline of the resident.

On 3/04/21 at 3:41 pm, surveyor notified the administrative team consisting of the interim administrator, interim DON, corporate MDS staff member, regional nurse, regional maintenance director, and the Chief Nursing Officer regarding Resident #35 receiving Digoxin when it should have been held on 2/19/21 due to a blood pressure of 94/52 and the resident not receiving treatments as ordered to the right buttock and left lower leg on 2/12/21, 2/15/21, and 2/18/21.

No further information regarding these issues

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F 684	Continued From page 6 was presented to the survey team prior to the exit conference on 3/04/21.	F 684		
F 686 SS=D	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 and clinical record review facility staff failed to provided wound care as ordered by the physician for 1 of 15 residents, Resident #28. Facility staff members failed to ensure Resident #28's wound care was performed according to medical provider orders. Resident #28's minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/29/2020 had the resident assessed as usually able to make self understood and as usually able to understand others. Resident #28's Brief Interview for Mental Status (BIMS) summary score was documented as 12 out of 15. Resident #28 was documented as being dependent with bed mobility, dressing, toilet use,	F 686	F686 Resident # 28 is receiving wound care for sacral wound and the right ischium wound as per MD orders. Current residents in the center with wounds have the potential to be affected. Licensed nurses will be educated by the Director of Nursing/designee on following MD orders for wound care and documentation on the electronic treatment administration record. Director of Nursing/designee will review ETAR reports 5x weekly daily in clinical	4/18/21

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F 686	Continued From page 7 personal hygiene, and eating. Resident #28's diagnoses included, but were not limited to: anemia, heart disease, high blood pressure, lung disease, diabetes, and paraplegia. Resident #28's clinical record included an order for daily wound care for a sacral wound. This order had a start date of 12/24/2020 and was a current order at the time of the survey. Resident #28's clinical record included an order for daily wound care for a right ischium wound. This order had a start date of 1/29/2021 and a discontinue date of 3/2/21. Review of Resident #28's treatment administration record (TAR) failed to provide documentation that the aforementioned two (2) wound care treatment orders were provided on 2/2/21, 2/7/21, 2/12/21, and 2/16/21. Resident #28 was care planned for wound care and care planned for being at risk for impaired skin integrity. These care plans included interventions to provide treatments according to the provider orders and the TAR. The absence of wound care documentation on the aforementioned dates was discussed with the facility's Regional MDS (minimum data set) Nurse (RMN) on 3/4/21 at 12:30 p.m. The RMN reported no reason for the missing wound care documentation was found. The failure of facility staff members to provide wound care as ordered by Resident #28's medical provider was discussed for a final time, on 3/4/21 at 3:32 p.m., with the facility's Interim Administrator, Interim Director of Nursing, RMN,	F 686	meeting to ensure wound care treatments are completed per MD orders. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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F 686	Continued From page 8 and Regional Nurse Consultant; no additional information related to this issue was provided to the survey team.	F 686		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and the review of documents, it was determined the facility staff failed to ensure tube feeding orders were correctly implemented for two (2) of 15 residents (Resident #17 and Resident #29). The findings include:	F 693	F693 Resident # 17 is receiving tube feedings as per MD orders. Resident #29 is receiving water flushes as per MD order with the appropriate order written when to turn the tube feeding off.	4/18/21

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F 693	Continued From page 9 1. Facility staff members failed to ensure Resident #17's tube feeding was administered as ordered by the medical provider as evidenced by: (a) observations of an Osmolite tube feeding container still hanging (although not running) greater than 11 hours after it should have been replaced with a new Osmolite tube feeding container and (b) the absence of documentation detailing when Resident #17's Osmolite tube feed and flushes were hung and replaced. Resident #17's minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/16/2020 had the resident assessed as usually able to make self understood and as able to understand others. Resident #17's Brief Interview for Mental Status (BIMS) summary score was documented as three (3) out of 15. Resident #17 was documented as being dependent for bed mobility, transfers, dressing, toilet use, personal hygiene, and eating. Resident #17's diagnoses included, but were not limited to: anemia, high blood pressure, respiratory failure, depression, and dementia. On 3/2/21 at 3:04 p.m., Resident #17's tube feeding was observed to be turned off. No documentation was found to indicate when and/or by whom the tube feeding had been turned off. Resident #17 had an empty 1000ml container of Osmolite hanging; this container was dated 3/1/21 at 1:00 p.m. Resident #17 had a container of water hanging with slightly less than 400ml of water remaining; this container of water was dated 3/1/21 at 2:00 p.m. These findings were shared with Licensed Practical Nurse (LPN) #2 (a unit manager) on 3/2/21 at 3:35 p.m. It was discussed with LPN #2 that Resident #17's Osmolite should have been changed	F 693	Current residents in the center receiving tube feeding have the potential to be affected. Licensed nurses will be educated by the Director of Nursing/designee on the center's policy for Enteral Feeding Guidelines. Education also included transcribing MD orders accurately for residents receiving tube feedings. Director of Nursing/designee will review in clinical meeting new tube feedings to ensure they are transcribed accurately. In addition, the Director of Nursing/designee will via direct observation 3x weekly to ensure tube feeding bottles and water flush bags are time and dated when hung. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON will be responsible for the implementation of the plan of correction.	

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F 693	Continued From page 10	F 693		

approximately 12 hours after being hung on 3/1/21 at 1:00 p.m. No documentation was provided to show the Osmolite had been hung at a different time than what was written on the bottle.

On 3/2/21 at approximately 3:35 p.m., Registered Nurse (RN) #2 was observed to hang a new container of Osmolite for Resident #17. During an interview on 3/2/21 at 3:45 p.m., RN #2 reported finding Resident #17's tube-feeding off just prior to the surveyor observing the tube feeding was off. RN #2 denied turning off Resident #17's tube feeding; RN #2 denied knowing who had turned off the tube feeding off. RN #2 reported having seen the tube-feeding running prior to discovering the tube feeding had been turned off.

Resident #17's enteral feeding orders included:
- 200ml free water flush every four (4) hours while tube feeding infuses
- Osmolite 1.5 at 85ml per hour daily from 8:00 a.m. - 6:00 a.m.

Resident #17 was care planned for enteral feeding. Resident #17's care plan included interventions to administer flushes and feeding per medical provider orders.

The following information was found in a facility document titled "Enteral Feeding Guidelines" (this document was not dated):
- "Labeling: Label each bottle with the following: Resident Name; Date/Time bottle hung; and Rate"
- "ACCUMULATED VOLUME is to be checked each night at 4 am. The total number of mLs [sic] delivered during the past 24 hours will be visible.

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F 693	Continued From page 11	F 693		

Press SELECT until Accum. Volume is displayed. Press CLEAR to reset to 0."

The following information was found in a facility document titled "Charting and Documentation" (this document was not dated):
- "Purpose 1. To provide a complete account of the resident's care, treatment, response to care, signs, symptoms, etc., as well as the progress of the resident's care. 2. To provide guidance to the physician in prescribing appropriate medications and treatments. 3. To provide a tool for measuring the quality of care provided to the resident."
- "Rules for Charting & Documenting 1. Chart all pertinent changes in the resident's condition, reaction to treatments, medications, etc., as well as routine observations. 2. Be concise, accurate, complete and use objective terms. Avoid brief, monotonous, or meaningless entries. 3. Document using only the facts ... 4. Chart as often as necessary and as the need arises ... 5. Document daily treatments and medications on the Treatment Administration Record (TAR) and Medication Administration Record (MAR) ..."

Resident #17's tube feeding observations and documentation was discussed during survey team meetings on 3/3/21 at 4:35 p.m. and 3/4/21 at 3:30 p.m. The following members of the facility's administrative team were present during the aforementioned survey team meetings: the Interim Administrator, the Interim Director of Nursing, the Regional MDS Nurse, and the Chief Nursing Officer.

2. For Resident #29, the facility staff failed to administer enteral water flushes as ordered by the physician on 3/02/21 and staff failed to

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accurately transcribe the physician's order for the enteral nutrition formula.

Resident #29's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Palsy Unspecified, Lennox-Gastaut Syndrome Not Intractable without Status Epilepticus, Functional Quadriplegia, and Dysphagia Unspecified.

The quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/30/20 coded the resident as being severely impaired in cognitive skills for daily decision making in section C, Cognitive Patterns. Resident #29 was also coded in section K, Swallowing/Nutritional Status, as receiving 51% or more of total calories received through parenteral or tube feeding and 501 cc/day or more average fluid intake per day by IV or tube feeding during the entire last 7 days.

On 3/02/21 at 4:36 pm surveyor observed Resident #29 in bed with Jevity 1.2 tube feeding formula being administered via pump with the rate set at 60 ml/hour. The bottle of Jevity 1.2 was dated 3/02/21 with no start time documented on the bottle, approximately 525ml of formula was remaining in the bottle. A fillable bag of water was hanging alongside the tube feeding formula. The water bag was dated 3/02/21 with no start time documented on the bag, over 1,000 ml of water remained in the bag. The pump was set to deliver a water flush of 70 ml every 0 hours. At 4:42 pm, surveyor spoke with RN #4 in Resident #29's room and asked when the water bag was hung. RN #4 stated the water was hung "last night" and "she didn't put the time did she". RN #4 stated the water flushes are ordered for 70 ml every hour while running; RN #4 looked at the pump and stated "it is sitting at 0, I'll have to redo

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that". Surveyor asked RN #4 if the resident received the ordered water flushes today and RN #4 replied "apparently (he/she) didn't, no" and "I flushed with (his/her) meds". At 4:49pm RN #4, with the assistance of another staff member, set the pump to deliver water flushes at 70 ml every 1 hour.

Resident #29 has an active physician's order dated 10/12/18 stating in part, "Free water flush: 70 ml per hour while TF (tube feeding) is running". Water flushes were signed off on the MAR (medication administration record) as being completed as ordered on 3/02/21 day shift.

Resident #29 also has an active physician's order dated 1/05/21 stating, "Enteral Feed Order every shift Jevity 1.2 @ (at) 60 ml/hr Start at 2100 (9:00 pm)". A dietary progress note dated 1/07/21 7:21 am states in part, "Resident continues with enteral feedings Jevity 1.2 @ 60/ML on at 2100 (9:00 pm) and turned off at 1600 (4:00 pm). Resident also receives free water flushes 70ml/hr while enteral feedings are running".

On 3/04/21 at 10:15am surveyor spoke with LPN (licensed practical nurse) #3, Resident #29's nurse, and asked when the resident's tube feeding is turned off each day, LPN #3 stated the resident "doesn't come off on my shift" and tube feeding is "already on when I get here". Surveyor asked if Resident #29's tube feeding is continuous and LPN #3 stated "(he/she's) continuous".

On 3/04/21 at 10:25 am surveyor spoke with the interim DON (director of nursing) who stated that "for years" Resident #29's tube feeding started at 9:00 pm and ended at 4:00 pm and on 1/05/21

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F 693	Continued From page 14 the dietician increased the tube feeding rate to 60 ml/hr and when they wrote the order, they did not add the 4:00 PM turn off time to the order. Resident #29's current care plan includes a focus area of "resident is at risk for significant weight changes and alteration in nutritional status as (he/she) requires feeding by gastrostomy tube secondary to: cerebral palsy and multiple other Dx (diagnosis), dysphagia, NPO (nothing by mouth) status, CHF (congestive heart failure), and risk for aspiration and complications" with interventions for "flushes per order" and "G tube feeding per MD order". On 3/04/21 at 3:41 pm, surveyor notified the administrative team consisting of the interim administrator, interim DON, corporate MDS staff member, regional nurse, regional maintenance director, and the Chief Nursing Officer regarding Resident #29 not receiving water flushes as ordered by the physician on 3/02/21 and the enteral feeding order not including a time to turn off the tube feeding formula. No further information regarding these issues was presented to the survey team prior to the exit conference on 3/04/21.	F 693		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		4/18/21

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F 756	Continued From page 15 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to act upon a monthly drug regimen review for 1 of 15 residents in the survey sample, Resident #48. The findings included:	F 756	F756 Resident #48 GDR was addressed on 3/4/21 by the provider. A review of the Pharmacy recommendations for the last 30 days was	

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F 756	Continued From page 16 For Resident #48, facility staff failed to address a drug regimen review completed by the pharmacist on 1/10/21 requesting a gradual dose reduction review for the psychotropic medications Diazepam, Mirtazapine, and Lexapro. Resident #48's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure with Hypoxia, Dependence on Respirator (Ventilator) Status, Quadriplegia Unspecified, Bipolar Disorder Unspecified, and Major Depressive Disorder Single Episode Unspecified. The annual MDS (minimum data set) with an ARD (assessment reference date) of 1/26/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive Patterns. Upon review of Resident #48's clinical record on 3/03/21, surveyor was unable to locate the January 2021 drug regimen review completed by the pharmacist. Surveyor spoke with the interim DON (director of nursing) and requested Resident #48's January 2021 drug regimen review. On 3/03/21 at 4:48 pm, the interim DON stated they were reaching out to the pharmacy to get a copy of the January 2021 drug regimen review and make sure it was done. Resident #48's current care plan includes a focus area stating, "resident at risk for adverse effect related to psychotropic medications secondary to dx (diagnosis) of: bipolar depression and anxiety" with an intervention stating "pharmacy review for medical necessity". On 3/04/21 at approximately 11:00 am, the	F 756	conducted to ensure GDR(s) have been addressed by the provider. The Director of Nursing will be educated by the Chief Nursing officer/designee to ensure Pharmacy recommendations are received and addressed timely. The Director of Nursing/designee will review Pharmacy recommendations in morning clinical meeting monthly to ensure the recommendations are received and addressed timely. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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interim DON provided surveyor with a copy of Resident #48's "(Pharmacy name omitted) Consultation Report" completed by the pharmacist on 1/10/21. The consultation report stated in part, "Comment: (Resident #48) has orders for the following medications that are due for GDR (gradual dose reduction) review/evaluation: Diazepam 10 mg twice daily for anxiety Mirtazapine 7.5 mg at bedtime for depression Lexapro 20 mg at bedtime for depression Recommendation: Please consider the possibility of a gradual dose reduction for one or more of the above medications, while concurrently monitoring for reemergence of target behaviors and/or withdrawal symptoms." This report did not include the physician's response, physician's signature, or the DON's signature.

On 3/04/21 at 12:11 pm, the interim DON stated the NP (nurse practitioner) is addressing Resident #48's drug regimen review today. Interim DON also stated that they could not find where it had been addressed and the NP could not remember with 100% accuracy if they had previously reviewed it.

On the afternoon of 3/04/21, the interim DON provided the surveyor with a copy of Resident #48's "(Pharmacy name omitted) Consultation Report" completed by the pharmacist on 1/10/21 that has now been addressed and signed by the NP on 3/04/21 and the DON on 3/04/21. The "Physician's Response" section of the consultation report is checked by the statement "I decline the recommendation(s) above because GDR is CLINICALLY CONTRAINDICATED for this individual as indicated below. (NOTE: Please check option #1 or #2 AND provide patient-specific rationale on the lines below.)"

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F 756	Continued From page 18 Option number one is checked by the statement "Continued use is in accordance with the current standard of practice and a GDR attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder AS DOCUMENTED BELOW, -OR-". Below the statement "Please provide CMS REQUIRED patient-specific rationale describing why a GDR attempt is likely to impair function or cause psychiatric instability in the individual:" the NP documented "In addition pt (patient) refused". On 3/04/21 at 3:41 pm, surveyor notified the administrative team consisting of the interim administrator, interim DON, corporate MDS staff member, regional nurse, regional maintenance director, and the Chief Nursing Officer that Resident #48's January 2021 pharmacy drug regimen review was not addressed. No further information regarding this issue was presented to the survey team prior to the exit conference on 3/04/21.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		4/18/21

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F 758	Continued From page 19 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff	F 758	F758	

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F 758	Continued From page 20 failed to ensure that residents were free from unnecessary psychotropic medications for 1 of 15 residents, Resident #25. The findings included: For Resident #25, the facility staff failed to monitor for resident specific targeted behaviors and side effects associated with the use of the psychotropic medication Alprazolam (a benzodiazepine used to relieve symptoms of anxiety). Resident #25's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure Unspecified Whether with Hypoxia or Hypercapnia, Dependence on Respirator (Ventilator) Status, Quadriplegia C5-C7 Complete, Type 2 Diabetes with Unspecified Diabetic Retinopathy without Macular Edema, Generalized Anxiety Disorder, and Major Depressive Disorder Recurrent Moderate. The quarterly MDS (minimum data set) with an ARD (assessment reference date) of 12/01/20 coded the resident as being severely impaired in cognitive skills for daily decision making with short term and long term memory loss in section C, Cognitive Patterns. A review of Resident #25's clinical record revealed an active physician's order dated 2/22/21 stating "Alprazolam Tablet 0.5 mg via G-Tube three times a day for anxiety". Resident #25's current care plan includes a focus area stating "resident at risk for adverse effect related to psychotropic medications secondary to dx (diagnosis) of: anxiety and depression" with	F 758	Resident #25 is having behaviors and side effects associated with the use of the Alprazolam monitored daily. A review for residents receiving psychotropic medication for the last 30 days was conducted to ensure behaviors and side effects are being monitored. Licensed nurses will be educated by the Director of Nursing/designee on monitoring behaviors and side effects of psychotropic medications. In addition, education included documentation on the electronic behavior monitoring record. Director of Nursing/Designee will review the electronic behavior monitoring record(EBMR) report 5x weekly to ensure monitoring of behaviors and side effects is being completed. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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F 758	Continued From page 21 interventions to "monitor behaviors related to psychotropic medications as needed" and "observe for adverse effects related to psychotropic medications". Surveyor was unable to locate documentation in Resident #25's clinical record for the monitoring of specific targeted behaviors for the use of Alprazolam or monitoring for any associated side effects. On 3/03/21 at 4:45 pm, surveyor notified the interim administrator, interim DON (director of nursing), corporate MDS staff member, and the CNO (chief nursing officer) of the concern regarding the lack of monitoring for targeted behaviors and side effects associated with Resident #25's use of Alprazolam. The interim DON stated it was not there but they added it. No further information regarding this issue was presented to the survey team prior to the exit conference on 3/04/21.	F 758		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and during a medication pass and pour observation, the facility staff failed to ensure a medication error rate of less than 5%. There were two (2) errors in 26 opportunities for a	F 759	F759 Resident #16, HCTZ was removed from the STAT box and administered as ordered to the resident on 3/4/2021.	4/18/21

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F 759	Continued From page 22 medication error rate of 7.69%. These medication errors affected Resident #16 and #19. The findings included: 1. For Resident #16, the facility staff failed to administer the residents physician ordered medication (HCTZ) hydrochlorothiazide. Resident #16's clinical record included the diagnosis quadriplegia, hypertension, and anxiety. Section C (cognitive patterns) of the residents quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 02/09/2021 included a (BIMS) brief interview for mental status summary score of 14 out of a possible 15 points. Resident #16's clinical record included an order for HCTZ 12.5 mg give 1 tablet by mouth one time a day related to essential hypertension. The residents comprehensive care plan included the intervention medications as ordered. On 03/03/2021 at approximately 8:30 a.m., (RN) registered nurse #1 was observed preparing and administering Resident #16's medications. During this observation, RN #1 stated the resident did not have any HCTZ and it had been reordered. On 03/03/21 at 10:13 a.m., the interim (DON) director of nursing, (RNC) regional nurse consultant, and administrator were made aware of the issue regarding the residents HCTZ. A review of the facility stat box list revealed that this medication was available in the stat box for administration.	F 759	Resident # 19 is receiving medications via route as per MD orders. Current residents in the facility have the potential to be affected. Licensed nurses will be educated by the Director of Nursing/designee on what medications are in the STAT box and the procedure for retrieving medications from the STAT box. In addition, the education included ensuring observing the 5 R(s) of medication administration including the route the medications are ordered. Director of Nursing/designee will review non-administered/held medication report 5x weekly to ensure medications not administered are not in the STAT box and the MD has been notified. In addition, the Director of Nursing/designee will observe 3 nurses weekly to ensure the 5 R(s) of medication administration is being conducted. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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On 03/03/21 at 1:00 p.m., RN #1 stated they did not know the medication was in the stat box.

On 03/04/2021 at 8:50 a.m., the unit manager stated they had obtained the HCTZ from the stat box and administered it to Resident #16. The facility provided the surveyor with a copy of a progress note dated 03/03/21 at 11:25 a.m. that read in part, "...(NP) nurse practitioner notified Medication pulled from STAT box, may administer late at this time."

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

2. For Resident #19, the facility staff administered the residents physician ordered medication by mouth when the order read administer via peg tube.

Resident #19's clinical record included the diagnosis hypertension and traumatic brain injury.

Section C (cognitive patterns) of the residents admission (MDS) minimum data set assessment with an (ARD) assessment reference date of 12/17/2020 included a (BIMS) brief interview for mental status summary score of 14 out of a possible 15 points. Section K (swallowing/nutritional status) was coded to indicate the resident had a feeding tube.

Resident #19's clinical record included a physicians order for hydralazine 50 mg 1 tablet via peg tube every 6 hours for hypertension.

Resident #19's comprehensive care plan included

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F 759	Continued From page 24 the focus area hypertension. Interventions included, administer medications as ordered. On 0302/21 at 5:80 p.m., (LPN) licensed practical nurse #1 was observed preparing and administering Resident #19's 6:00 p.m. medication hydralazine. LPN #1 was observed to crush this medication, place it applesauce, and administer it to Resident #19 via mouth. Resident #19 tolerated the medication without difficulty. Resident #19's clinical record included a physicians order for a mechanical soft diet. On 03/03/21 at 10:13 a.m., the interim (DON) director of nursing, (RNC) regional nurse consultant, and administrator were made aware of the issue regarding the residents hydralazine being administered via mouth and not by peg as ordered. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 759		
F 880 SS=D	. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		4/18/21

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F 880	Continued From page 25	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 26 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and the review of documents, it was determined facility staff members failed to perform hand hygiene when changing gloves during wound care for two (2) of 15 sampled residents (Resident #24 and Resident #32). The findings include: 1. A facility staff member failed to appropriately perform hand hygiene while changing Resident #24's dressings. Resident #24's minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/8/21 had the resident assessed as being in a persistent vegetative state/no discernible consciousness. Resident #24 was	F 880	F880 LPN #1 was immediately educated on the proper hand hygiene to be performed during wound care. Current residents in the center with wounds have the potential to be affected. Licensed nurses will be educated by the Director of Nursing/designee on the center's policy for wound care and proper hand hygiene while performing wound care. Director of Nursing/designee will observe wound care 3x weekly to ensure compliance with handwashing during	

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F 880	Continued From page 27 documented as being dependent for all activities of daily living (ADLs). Resident #24's diagnoses included, but were not limited to: anemia, high blood pressure, quadriplegia, seizures, and respiratory failure. Resident #24's clinical record included orders for wound cleaning and dressing changes for the following areas: (a) left posterior scalp, (b) right ischium, and (c) PEG site. On 3/3/21, Licensed Practical Nurse (LPN) #1 was observed to provide Resident #24's wound care to the three (3) aforementioned areas. LPN #2 and Registered Nurse (RN) #11 was present during the wound care. LPN #1 changed gloves without completing hand hygiene after removing the soiled dressings and prior to applying the new dressings for the three (3) aforementioned areas. The following information was found in a facility document titled "Wound Care/Treatment Guidelines" (this document was not dated): - "Purpose ... To provide guidelines for wound care to promote healing." - "Steps in Procedure ... 5. Wash hands 6. Explain the procedure to the resident. 7. Cut the tape with your clean scissors. 8. Put gloves on. 9. Remove the soiled dressing and place in a bag at the bedside. Place the soiled scissors on one corner of your setup not touching supplies. 10. Remove gloves and discard in the bag. 11. Clean the scissors with 60 seconds of contact with alcohol and place on a CLEAN corner of your setup. 12. Wash hands. 13. Put on clean gloves ..." The following information was found in a facility document titled "Hand Hygiene" (this document	F 880	wound care and oversite of infection control practices. The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis. The CAO/DON will be responsible for implementation of the plan of correction.	

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F 880	Continued From page 28	F 880		

was not dated):
- "Purpose ... The purpose of this procedure is to provide guidelines to employees for proper and appropriate hand hygiene techniques that will aid in the prevention of the transmission of infections."
- "Objectives ... To prevent the spread of infectious diseases."
- "When to Wash Hands ... 6. After handling used dressings, specimen containers, contaminated tissues, linen, etc. ... 9. After removing gloves ..."

Resident #24's wound care observations, where a staff member changed gloves without performing hand hygiene, were discussed during survey team meetings on 3/3/21 at 4:35 p.m. and 3/4/21 at 3:30 p.m. The following members of the facility's administrative team were present during these survey team meetings: the Interim Administrator, the Interim Director of Nursing, the Regional MDS Nurse, and the Chief Nursing Officer.

2. A facility staff member failed to appropriately perform hand hygiene while changing Resident #32's dressing.

Resident #32's minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/21/20 had the resident assessed as being in a persistent vegetative state/no discernible consciousness. Resident #32 was documented as being dependent for all activities of daily living (ADLS). Resident #32's diagnoses included, but were not limited to: anemia, high blood pressure, seizures, and respiratory failure.

Resident #32's clinical record included an order

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F 880	Continued From page 29 for wound cleaning and dressing change for a sacral wound. On 3/3/21, Licensed Practical Nurse (LPN) #2 was observed to provide Resident #32's sacral wound care. Registered Nurse (RN) #11 was present during the wound care. LPN #2 changed gloves, without completing hand hygiene, after removing the soiled dressing and prior to applying the new dressing. Resident #32's wound care observation, where a staff member changed gloves without performing hand hygiene, was discussed during survey team meetings on 3/3/21 at 4:35 p.m. and 3/4/21 at 3:30 p.m. The following members of the facility's administrative team were present during these survey team meetings: the Interim Administrator, the Interim Director of Nursing, the Regional MDS Nurse, and the Chief Nursing Officer.	F 880		