STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495332	A. BUILDING _____ B. WING _____	C 02/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD	101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430

(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 02/23/21 through 02/25/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare standard survey was conducted 02/23/21 through 02/25/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaint were investigated during the survey: VA00048948 and VA00049197. Twenty facility residents tested positive for the COVID-19 virus, 17 recovered. At the time of the survey, there were no current residents that tested positive for the virus. Eighteen facility employee tested positive for the COVID-19 virus, 17 returned to work and 1 remained quarantined at home at the time of the survey. The census in this 34 certified bed facility was 22 at the time of the survey. The survey sample consisted of 20 resident reviews: 15 current Resident reviews and 5 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §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-	F 580		4/9/21

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

Electronically Signed | 03/19/2021

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F 580	Continued From page 1	F 580		

(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).

§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

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F 580	Continued From page 2 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 information gleamed during a complaint investigation, a complainant interview, staff interviews, clinical record review, and review of facility documents, the facility's staff failed to notify the resident representative of a change in condition for 1 of 20 residents (Resident #21), in the survey sample. The findings included: Resident #21 was originally admitted to the facility 4/24/20, and was discharged 5/4/20, return not anticipated therefore; a closed record review was conducted. Resident #21's diagnoses included; a total right knee replacement, diabetes and hyperlipidemia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/30/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility, extensive assistance of one person with bathing, toileting and dressing, limited assistance of one person with transfers, walking in room and personal hygiene and independent after set-up with eating. During the interview with the complainant on	F 580	F580 SS=D Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) cross tag 12 VAC 5-371-220(B,D,H) 1. Resident #21 no longer resides at the facility and was discharged on 5/15/2020. The nurse was educated 1:1 by the DON on notification of changes in condition on 2/24/2021. 2. All TARs on current residents will be reviewed by the DON/Designee since 2/25/2021 to ensure that residents with pressure injuries Responsible Representatives have been notified and notification has been documented. 3. The DON/Designee will review the 24HR report during morning huddle to identify new orders requiring Resident Representative notification, change in condition and verify notifications are communicated and documented to the Resident Representative. The Clinical Educator/Designee will provide education to the nursing staff on compliance with Resident Representative notification by 4/9/2021. 4. The DON/Designee will conduct audits on 6 residents per week for 4 weeks and then 3 residents per week for 8 weeks to verify that changes in condition have been communicated to the Resident	

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F 580	Continued From page 3 2/23/21 at 1:20 p.m., the complainant stated the facility's staff never notified her that Resident #21 had acquired a pressure ulcer while at the facility. The complainant stated on the day of discharge the resident was very uncomfortable and unable to sit on her behind when they arrived home from the facility therefore; she assisted her to undress and that was when she first learned of the open areas to her behind. The complainant stated the open area were uncovered and large. The complainant stated she immediately telephoned the facility to inquire of the open areas to the resident's behind and asked how to care for them but the staff didn't seem to care since the resident had been discharged. Review of Resident #21's clinical record revealed she was admitted without an open area to her buttock. The Braden scale completed on 4/24/20 and 5/8/20 indicated the resident was a mild risk for development of a pressure ulcer. Nurses' notes stated the resident toileted and was mostly continent of her bladder and bowels but she required assistance with transfers and bed mobility because of the right knee limitations. Further review of Resident #21's clinical record revealed on 5/9/20 the staff identified an open area measuring 0.5 centimeters by 0.5 centimeters to the right lower buttock. An order was obtained to treat the open area. The order read; cleanse the right buttock gently with normal saline and pat dry. Apply an oil emulsion dressing to the open area and a foam dressing every three days. Review of Resident #21's treatment record revealed the right buttock dressing change was performed 5/10/20 and 5/13/20.	F 580	Representative and documented in the medical record. The results of the audits will be reported quarterly at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	

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F 580	Continued From page 4	F 580		

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 2/24/21 at approximately 3:40 p.m. LPN #1 stated she was the nurse who originally assessed the open area to Resident #21's buttock and she obtained the initial order for care. She further stated she hadn't been trained to determine types of wounds or staging therefore; a staff member trained in wound assessment was responsible to complete an in-depth assessment and determine the most appropriate treatment.

An interview was conducted with the Director of Nursing on 2/25/21 at approximately 11:30 a.m. The Director of Nursing stated LPN #1 duties included to immediately assess and measure the wound, notify the provider and resident representative, start the ordered treatment, complete rCare documents, a nurses note, write the nursing care plan, notify nursing management, and the on-coming shift until the area was healed. The Director of Nursing further stated the next business day the nurse leader/wound champion's investigation report wasn't completed and the etiology wasn't determined. Neither was the Director of Nursing able to locate documentation the resident representative was notified of the original finding of the open area or documentation stating at the time of Resident #21's discharge that the resident representative was notified of the residents open wound and was made aware of orders to treat the open area.

On 2/25/21 at approximately 3:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Director of Nursing stated the expectation is for the nurse to notify

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F 580	Continued From page 5 the resident representative of changes in condition and when the algorithm is utilized it guides the nurse to ensure all necessary measures are met. The Administrator stated she understood the concern and had no additional information to offer.	F 580		
F 582 SS=D	Complaint Deficiency 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		4/9/21

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F 582	Continued From page 6 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 clinical record review, staff interview and facility documentation, the facility staff failed to ensure Medicare Beneficiary Notices in accordance with applicable Federal regulations, were issued to 2 of 3 residents (Resident #2 and Resident #13) out of 20 in the survey sample. The facility staff failed to issue an Advanced Beneficiary Notice (ABN) letter to Resident #2 who was discharged from skilled services with Medicare days remaining. The findings included:	F 582	F582 SS=D Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) cross tag 12 VAC 5-371-150 B1 (C, D, G, & F) 1. ABNs were provided to the two residents identified as not having receiving ABNs on 2/24/2021. The Administrator provided 1:1 education to the Social Worker in the process of issuing ABN forms to resident/Resident Representatives #2 and #13 on	

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F 582	Continued From page 7 1. Resident #2 was admitted to the nursing facility on 11/16/20. Diagnosis for Resident #2 included but not limited to Generalized Muscle Weakness. Resident #2's Minimum Data Set (MDS) an OBRA Admission Assessment with an Assessment Reference Date (ARD) date of 11/21/20 coded Resident #2 a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated no cognitive impairment. Review of the SNF Beneficiary Notification Review provided by the facility to surveyor, was noted that Resident #2 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice.). The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage), however; no copy of the SNF ABN was provided. Resident #2 started a Medicare Part A stay on 11/17/20 and the last covered day of this stay was 11/27/20. Resident #2 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #2 had only used 12 days of her Medicare Part A services with 88 days remaining. Resident #2 should have been issued a SNF ABN and an NOMNC. Resident #2 was only issued an NOMNC. An interview was conducted with the Social Worker (SW) on 02/24/21 at approximately 2:45 p.m. He stated, "I'm not sure what happened; I can't find a copy of the SNF ABN letter for Resident #2." When asked, if an ABN letter should have been issued to Resident #2, the SW replied, "Yes."	F 582	2/24/2021. 2. On 3/16/2021, the Social Worker audited all Medicare A discharges to NF/LTC to ensure that all ABNs were issued as appropriate. All findings were appropriate. 3. The Administrator/Designee will review all upcoming level of care changes and verify at the morning meeting each weekday that the ABN has been provided. Education was provided to the Social Worker by the Administrator by 3/23/2021. 4. The Business Office/Designee will audit 2 residents who have discharged from SNF services with Medicare A skilled days remaining for 4 weeks, and then 1 resident per week for 8 weeks to ensure that the ABN was issued. The results of the audits will be reported quarterly at the QAPI meeting by the Administrator/ Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	

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F 582	Continued From page 8	F 582		

2. Resident #13 was admitted to the nursing facility on 12/24/20. Diagnosis for Resident #13 included but not limited to Generalized Muscle Weakness. Resident #13's Minimum Data Set (MDS) an OBRA Admission Assessment with an Assessment Reference Date (ARD) date of 12/30/20 coded Resident #13 a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicated no cognitive impairment.

Review of the SNF Beneficiary Notification Review provided by the facility to surveyor, was noted that Resident #13 was not listed for having been issued the SNF ABN (Skilled Nursing Facility-Advanced Beneficiary Notice.) The resident had received a NOMNC (Notice of Medicare Provider Non-Coverage), however; no copy of the SNF ABN was provided.

Resident #13 started a Medicare Part A stay on 12/26/20, and the last covered day of this stay was 01/25/20. Resident #13 was discharged from Medicare Part A services when benefit days were not exhausted. Resident #13 only used 39 days of his Medicare Part A services with 61 days remaining. Resident #13 should have been issued a SNF ABN and an NOMNC. Resident #13 was only issued an NOMNC.

An interview was conducted with the Social Worker (SW) on 02/24/21 at approximately 2:45 p.m. He stated, "I'm not sure what happened; I can't find a copy of the ABN letter." When asked, if an ABN letter should have been issued to Resident #13" the SW replied, "Yes."

The Administrator and Director of Nursing DON) was informed during the debriefing on 02/25/21 at

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F 582	Continued From page 9 approximately 3:45 p.m. The facility did not present any further information about the findings. The facility's policy titled: Daily Skilled Review Procedure, revision date: 12/06/19. Purpose: To ensure interdisciplinary team (IDT) identifies and address skilled resident's needs from admission to discharge. -Procedure: Supplemental Guidance read in part: Date of NOMNC and ABN from Social Services or Business Office Liaison (BOL.)	F 582		
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	F 622		4/9/21

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F 622	Continued From page 10	F 622		

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 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-

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F 622	Continued From page 11 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and facility documentation review, the facility staff failed to convey the summary of goals of the comprehensive plan of care upon transfer/discharge for 1 of 20 residents (Resident #23) in the survey sample. The findings include: The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 1/6/21 or as soon as possible to the actual time of transfer for Resident #23.	F 622	F622 SS=D Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) cross tag 12 VAC 5-371-150 B1 (C, D, G, & F) 1. Resident #23 no longer resides at the facility and was discharged on 1/6/2021. 2. All residents who were in the hospital as of 2/19/2021 had their plan of care summary sent to the hospital so that the acute care hospital has the required information. 3. Licensed Nurses have been educated by the Clinical Educator/Designee on the discharge process that meets the	

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RIVERSIDE HEALTHY LIVING COMMUNITY-SMITHFIELD	101 JOHN ROLFE DRIVE SMITHFIELD, VA 23430

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F 622	Continued From page 12 Resident #23 was admitted to the nursing facility on 12/15/20 with diagnoses that included lung and bladder cancer. Resident #23's most recent Minimum Data Set (MDS) assessment was an Annual dated 12/21/20 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 00 out of a possible score of 15 which indicated the resident was severely impaired in the skills for daily decision making. The nurse's notes dated 1/6/21 indicated the nurse was called to the room by other clinical staff members. Resident was sitting in a wheelchair in obvious distress. He was transferred back to bed via a Hoyer (brand name mechanical lift) and 2 person CPR started while 911 was called at approximately 7:31 a.m. Paramedics arrived at 07:45 a.m. and took over CPR. The daughter and physician was notified of the situation. Paramedics were able to get a pulse and the resident left the building to be transferred to (name of local hospital). There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital. On 2/25/21 at 9:30 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON). They stated that care plan goals and summary report should be sent with the resident if possible and if not be forwarded by email, but mostly faxed to the hospital in this case, but it wasn't and this is something we are going to fix through in-services. They said, "When	F 622	regulatory requirements for information provided to receiving providers/healthcare institutions by 4/9/2021. 4. A transfer/discharge audit form has been developed and will be updated daily as needed by the DON/Designee to validate the plan of care summary has been sent with the transferring resident to the receiving healthcare institution. DON/Designee will audit all discharges to the hospital for 8 weeks to ensure that the plan of care summary was provided to the hospital. The results of the audits will be reported quarterly at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	

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F 622	Continued From page 13 a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after." The facility's policy titled Nursing Home Discharge/Transfer Policy dated 12/11/19 indicated that the hospital of receiving facility will be provided with all applicable state and federal notices at the time of transfer or as soon as possible for emergent discharges/transfers, including comprehensive care plan goals and discharge summary.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		4/9/21

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F 623	Continued From page 14 §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 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	F 623		

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F 623	Continued From page 15 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 relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews,	F 623	F623	

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F 623	Continued From page 16 and facility document review the facility staff failed to notify the office of the State Long-Term Care Ombudsman in writing of applicable discharges for 1 of 20 residents in the survey sample (Resident #23). The findings included: The facility staff failed to notify the office of the State Long-Term Care Ombudsman of Resident #23's discharge to the hospital on 1/6/20. Resident #23 was admitted to the nursing facility on 12/15/20 with diagnoses that included lung and bladder cancer. Resident #23's most recent Minimum Data Set (MDS) assessment was an Annual dated 12/21/20 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 00 out of a possible score of 15 which indicated the resident was severely impaired in the skills for daily decision making. The nurse's notes dated 1/6/21 indicated the nurse was called to the room by other clinical staff members. Resident was sitting in a wheelchair in obvious distress. He was transferred back to bed via a Hoyer (brand name mechanical lift) and 2 person CPR started while 911 was called at approximately 7:31 a.m. Paramedics arrived at 07:45 a.m. and took over CPR. The daughter and physician was notified of the situation. Paramedics were able to get a pulse and the resident left the building to be transferred to (name of local hospital). On 2/25/21 at 2:30 p.m., the Admission's Coordinator presented the Transfer/Discharge	F 623	SS=D Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) cross tag 12 VAC 5-371-150 B1 (C, D, G, & F) 1. Resident #23 no longer resides at the facility and was discharged on 1/6/2021. Since 2/25/2021, the ombudsman has been notified of all facility initiated discharges by the Admissions Coordinator. 2. The Admissions Coordinator/Designee will complete an audit of all discharges since 2/25/2021 to ensure all discharge notifications were issued to the ombudsman. Results of the audit will be forwarded to the QAPI Committee by the Admissions Coordinator. Variances will be corrected with prompt notification to the state ombudsman. 3. Administrator/Designee will educate Clinical Staff and Interdisciplinary Team on the requirement to provide discharge notification to the state long term care ombudsman. As of 3/16/2021, IDT reviews all facility initiated discharges every weekday in morning huddle. Each facility initiated discharge notification is faxed and a copy and confirmation is kept in the residents Business Office file. 4. For 4 weeks, the Admissions Coordinator/Designee will conduct a weekly audit of 3 facility-initiated discharges, and then 2 weekly for 8 weeks to ensure that the ombudsman was notified. The results of the audits will be reported quarterly at the QAPI meeting	

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F 623	Continued From page 17 Notice that indicated the State Long-Term Care Ombudsman was notified of Resident #23's transfer to the hospital on 2/25/21 at 2:22 p.m. She stated, " I am supposed to do this, but I missed some and this is one I missed, but I at least I informed them after you asked me for it. We normally send out as soon as we can or at least a monthly notification to the Ombudsman. This one should have been sent by the end of January 2021." On 2/25/21 at 9:30 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON). They stated that the Admission's Coordinator is responsible to maintain a list of transfers and discharges from the facility to be sent to the Ombudsman either as soon as they are transferred, but at least on a monthly basis. The Administrator stated she would audit any that were missed and ensure notification to the Ombudsman in timely. The facility's policy titled Nursing Home Discharge/Transfer Policy dated 12/11/19 indicated that all applicable state and federal notices to include emergent transfers or discharges to the hospital and to home (immediate or 30 day as applicable) will be forwarded to the State Ombudsman.	F 623	by the Admissions Coordinator/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		4/9/21

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F 625	Continued From page 18 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: The findings include: The facility staff failed to include a bed-hold policy at the time of discharge to the local hospital on 1/6/21 or as soon as possible to the actual time of transfer for Resident #23. Resident #23 was admitted to the nursing facility on 12/15/20 with diagnoses that included lung and bladder cancer. Resident #23's most recent Minimum Data Set (MDS) assessment was an Annual dated 12/21/20 and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of	F 625	F625 SS=D Notice of Bed Hold Policy Before/Upon Transfer CFR(s): 483.15(d)(1)(2) cross tag 12 VAC 5-371-150 B1 (C, D, G, & F) 1. Resident #23 no longer resides at the facility and was discharged on 1/6/2021 to the hospital and expired. 2. By 3/19/2021, the Business Office/Designee will complete an audit of all hospital discharges since 2/25/2021 to ensure that the bed hold policy was issued to the resident/Resident	

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F 625	Continued From page 19 00 out of a possible score of 15 which indicated the resident was severely impaired in the skills for daily decision making. The nurse's notes dated 1/6/21 indicated the nurse was called to the room by other clinical staff members. Resident was sitting in a wheelchair in obvious distress. He was transferred back to bed via a Hoyer (brand name mechanical lift) and 2 person CPR started while 911 was called at approximately 7:31 a.m. Paramedics arrived at 07:45 a.m. and took over CPR. The daughter and physician was notified of the situation. Paramedics were able to get a pulse and the resident left the building to be transferred to (name of local hospital). There was no documentation in the clinical record that facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge or soon thereafter to the local hospital. On 2/25/21 at 9:30 a.m., an interview was conducted with the Administrator and the Director of Nursing (DON). They stated that the bed hold policy/notice in the case of Resident #23 who would have not been able to comprehend the notice, we would make sure the Resident Representative (RR) received our bed hold policy/notice and it was documented accordingly. They said, "When a resident is transferred to the ER or the hospital the nurse is prompted through a check list in the computer for the specific resident that in turn generates the transfer summary that includes the care plan summary with goals as well as the bed hold notice, but there is no way to confirm the documents was sent at the time of the transfer or that it was sent over to the ED or hospital soon after."	F 625	Representative who are currently hospitalized. All results will be reported to the QAPI Committee. 3. DON/Designee will re-educate the Licensed Clinical Staff and IDT concerning bed hold requirements and the process for issuing and confirming a bed hold. The Business Office/Designee will check daily to ensure the bed hold policy was appropriately issued to each resident/Resident Representative by the discharging nurse/designee. 4. The Admissions Coordinator/Designee will audit 3 hospital discharges for 4 weeks and then 1 hospital discharge per week for 8 weeks to ensure the bed hold policy was issued. The results of the audits will be reported quarterly at the QAPI meeting by the Admissions Coordinator/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	

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F 625	Continued From page 20 The facility's policy titled Nursing Home Discharge/Transfer Policy dated 12/11/19 indicated that the resident/representative will be provided with all applicable state and federal notices at the time of transfer or leave of absence as soon as possible including the bed hold policy.	F 625		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.	F 661		4/9/21

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F 661	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on information gleamed during a complaint investigation, a complainant interview, staff interviews, and clinical record review, the facility's staff failed to communicate pertinent information to the resident and resident representative at the time of an anticipated discharge, for 1 of 20 residents (Resident #21), in the survey sample. The findings included: Resident #21 was originally admitted to the facility 4/24/20, and was discharged 5/4/20, return not anticipated therefore; a closed record review was conducted. Resident #21's diagnoses included; a total right knee replacement, diabetes and hyperlipidemia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/30/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility, extensive assistance of one person with bathing, toileting and dressing, limited assistance of one person with transfers, walking in room and personal hygiene and independent after set-up with eating. During the interview with the complainant on 2/23/21 at 1:20 p.m., the complainant stated the facility's staff never notified her that Resident #21 had acquired a pressure ulcer while at the facility.	F 661	F661 SS=D Discharge Summary CFR(s): 483.21 (c)(2)(i)-(iv) 1. Resident #21 no longer resides at the facility and was discharged on 5/15/2020. The nurse was educated 1:1 by the DON on providing instructions to the Resident Representative on pertinent information at time of discharge on 2/24/2021. 2. All planned discharges since 2/25/2021 will be reviewed by the DON/Designee to ensure that pertinent information to the resident/Resident Representatives at the time of the anticipated discharge was communicated. 3. The Clinical Educator/Designee will review discharge instructions of residents with skin integrity concerns prior to anticipated discharge. The Clinical Educator/Designee will provide education to the nursing staff on communicating pertinent information to the resident/Resident Representative at the time of discharge by 4/9/2021. 4. The DON/Designee will conduct audits on 3 discharged (planned) residents per week for 4 weeks, then 2 discharged residents for 8 weeks to verify that pertinent information related to skin integrity has been communicated to the resident/Resident Representative. The results of the audits will be reported quarterly at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for	

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F 661	Continued From page 22 The complainant stated on the day of discharge the resident was very uncomfortable and unable to sit on her behind when they arrived home from the facility therefore; she assisted her to undress and that was when she first learned of the open areas to her behind. The complainant stated the open area were uncovered and large. The complainant stated she immediately telephoned the facility to inquire of the open areas to the resident's behind and asked how to care for them but the staff didn't seem to care since the resident had been discharged. Review of Resident #21's clinical record revealed she was admitted without a open areas to her buttock. The Braden scale completed on 4/24/20 and 5/8/20 indicated the resident was a mild risk for development of a pressure ulcer. Nurses's notes stated the resident toileted and was mostly continent of her bladder and bowels but she required assistance with transfers and bed mobility because of the right knee limitations. Further review of Resident #21's clinical record revealed on 5/9/20 the staff identified an open area measuring 0.5 centimeters by 0.5 centimeters to the right lower buttock. An order was obtained to treat the open area. The order read; cleanse the right buttock gently with normal saline and pat dry. Apply an oil emulsion dressing to the open area and a foam dressing every three days. Review of Resident #21's treatment record revealed the right buttock dressing change was performed 5/10/20 and 5/13/20. An interview was conducted with Licensed Practical Nurse (LPN) #1 on 2/24/21 at	F 661	continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	

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	495332	A. BUILDING _____ B. WING _____	C 02/25/2021

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F 661	Continued From page 23	F 661		

approximately 3:40 p.m. LPN #1 stated she was the nurse who originally assessed the open area to Resident #21's buttock and she obtained the initial order for care. She further stated she hadn't been trained to determine types of wounds or staging therefore; a staff member trained in wound assessment was responsible to complete an in-depth assessment and determine the most appropriate treatment.

An interview was conducted with the Director of Nursing on 2/25/21 at approximately 11:30 a.m. The Director of Nursing stated LPN #1 duties included to immediately assess and measure the wound, notify the provider and resident representative, start the ordered treatment, complete rCare documents, a nurses note, write the nursing care plan, notify nursing management, and the on-coming shift until the area was healed. The Director of Nursing further stated the next business day the nurse leader/wound champion's investigation report wasn't completed and the etiology wasn't determined. Neither was the Director of Nursing able to locate documentation the resident representative was notified of the original finding of the open area or documentation stating at the time of Resident #21's discharge that the resident representative was notified of the residents open wound and was made aware of orders to treat the open area.

On 2/25/21 at approximately 3:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Director of Nursing stated the expectation is for the nurse to explain important information from the discharge summary to the resident and resident representative and have the information written

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F 661	Continued From page 24 on the discharge summary so there is something to refer to if needed. The Administrator stated she understood the concern and had no additional information to offer.	F 661		
F 686 SS=D	Complaint Deficiency 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 information gleamed during a complaint investigation, a complainant interview, staff interviews, and clinical record review, the facility's staff failed to ensure a resident with pressure ulcers received necessary treatment and services to promote healing for 1 of 20 residents (Resident #21), in the survey sample. The findings included: Resident #21 was originally admitted to the facility 4/24/20, and was discharged 5/4/20, return not anticipated therefore; a closed record review was	F 686	F686 SS=D Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) cross tag 12 VAC 5-371-220(B,D,H) 1. Resident #21 no longer resides at the facility and was discharged on 5/15/2020. The nurse was educated 1:1 by the DON on notification of changes in condition and new orders for treatments on 2/24/2021. The nurse was educated 1:1 by the DON	4/9/21

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F 686	Continued From page 25 conducted. Resident #21's diagnoses included; a total right knee replacement, diabetes and hyperlipidemia. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/30/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #21's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility, extensive assistance of one person with bathing, toileting and dressing, limited assistance of one person with transfers, walking in room and personal hygiene and independent after set-up with eating. During the interview with the complainant on 2/23/21 at 1:20 p.m., the complainant stated the facility's staff never notified her that Resident #21 had acquired a pressure ulcer while at the facility. The complainant stated on the day of discharge the resident was very uncomfortable and unable to sit on her behind when they arrived home from the facility therefore; she assisted her to undress and that was when she first learned of the open areas to her behind. The complainant stated the open area were uncovered and large. The complainant stated she immediately telephoned the facility to inquire of the open areas to the resident's behind and asked how to care for them but the staff didn't seem to care since the resident had been discharged. Review of Resident #21's clinical record revealed she was admitted without a open areas to her buttock. The Braden scale completed on 4/24/20	F 686	on providing instructions to the Resident Representative on pertinent information at time of discharge on 2/24/2021. 2. All TARs on current residents will be reviewed by the DON/Designee since 2/25/2021 to ensure that residents with pressure injuries Responsible Representatives have been notified of changes in treatment orders and notification has been documented. All planned discharges since 2/25/2021 will be reviewed by the DON/Designee to ensure that pertinent information related to treatments are communicated to the resident/Resident Representatives at the time of the anticipated discharge. 3. The DON/Designee will review the 24HR report during morning huddle to identify new orders and treatment changes requiring Resident Representative notification, change in condition and verify notifications are communicated and documented to the Resident Representative. The Clinical Educator/Designee will provide education to the nursing staff on compliance with Resident Representative notification of current skin integrity concerns and changes in treatment orders by 4/9/2021. The Clinical Educator/Designee will review discharge instructions of residents with skin integrity concerns prior to anticipated discharge. The Clinical Educator/Designee will provide education to the nursing staff on communicating pertinent information related to treatments to the resident/Resident Representative at the time of discharge by 4/9/2021. 4. The DON/Designee will conduct	

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F 686	Continued From page 26	F 686		

and 5/8/20 indicated the resident was a mild risk for development of a pressure ulcer. Nurses's notes stated the resident toileted and was mostly continent of her bladder and bowels but she required assistance with transfers and bed mobility because of the right knee limitations.

Further review of Resident #21's clinical record revealed on 5/9/20 the staff identified an open area measuring 0.5 centimeters by 0.5 centimeters to the right lower buttock. An order was obtained to treat the open area. The order read; cleanse the right buttock gently with normal saline and pat dry. Apply an oil emulsion dressing to the open area and a foam dressing every three days.

Review of Resident #21's treatment record revealed the right buttock dressing change was performed 5/10/20 and 5/13/20.

An interview was conducted with Licensed Practical Nurse (LPN) #1 on 2/24/21 at approximately 3:40 p.m. LPN #1 stated she was the nurse who originally assessed the open area to Resident #21's buttock and she obtained the initial order for care. She further stated she hadn't been trained to determine types of wounds or staging therefore; a staff member trained in wound assessment was responsible to complete an in-depth assessment and determine the most appropriate treatment.

An interview was conducted with the Director of Nursing on 2/25/21 at approximately 11:30 a.m. The Director of Nursing stated LPN #1 duties included to immediately assess and measure the wound, notify the provider and resident representative, start the ordered treatment,

audits on 6 residents per week for 4 weeks and then 3 residents per week for 8 weeks to verify that changes in condition have been communicated to the Resident Representative and documented in the medical record. The DON/Designee will conduct audits on 3 discharged (planned) residents per week for 4 weeks, then 2 discharged residents for 8 weeks to verify that pertinent information related to skin integrity has been communicated to the resident/Resident Representative. The results of the audits will be reported quarterly at the QAPI meeting by the DON/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation.
5. All corrective actions will be completed by 4/9/2021.

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F 686	Continued From page 27	F 686		

complete rCare documents, a nurses note, write the nursing care plan, notify nursing management, and the on-coming shift until the area was healed. The Director of Nursing further stated the next business day the nurse leader/wound champion's investigation report wasn't completed and the etiology wasn't determined. Neither was the Director of Nursing able to locate documentation the resident representative was notified of the original finding of the open area or documentation stating at the time of Resident #21's discharge that the resident representative was notified of the residents open wound and was made aware of orders to treat the open area.

Review of a Physician's progress note dated 5/16/21, revealed Resident #21 presented to the practice with two stage 2 pressure ulcers, one to each buttock, more superficial. No measurements were documented. New orders were obtained to keep the area clean and dry as possible with dry bandages, apply a light layer of Bactroban ointment to the affected areas three times per day and allow the area to air out if possible.

On 2/25/21 at approximately 3:00 p.m., the above findings were shared with the Administrator and the Director of Nursing. The Director of Nursing stated the expectation was for the nurse to notify the nurse leader/wound champion so a through investigation and etiology could be determined and it appeared that didn't occur therefore; all wound care measures were not instituted. The Administrator stated she understood the concern and had no additional information to offer.

Complaint Deficiency

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F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and clinical record review the facility staff failed to ensure one resident (Resident #15, in the survey sample of twenty Residents) who is unable to carry out activities of daily living receives the necessary services to maintain toenail care. The facility staff failed to ensure that podiatry services were provided to Resident #15. The findings included: Resident #15 was originally admitted to the facility on 07/31/20. Diagnosis for Resident #15 included but not limited to Type II Diabetes Mellitus, Onychomycosis and Peripheral Vascular Disease. The most recent Minimum Data Set (MDS) was a quarterly revision with an Assessment Reference Date (ARD) of 01/19/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 6 which indicated cognitive impairment for daily decision-making. Resident #15 was	F 687	F687 SS=D Foot Care CFR(s): 483.25 (b)(2)(i)(ii) cross tag 12 VAC 5-371-220(B,D,H) 1. Resident #15 had his toe nails trimmed by the DON on 3/5/2021. The resident will be seen by the podiatrist on the next scheduled visit on 3/17/2021. 2. DON completed a 100% audit of all resident toe nails on 3/11/2021. Any identified concerns will be see by the podiatrist on the next scheduled visit on 3/17/2021. 3. The DON/Designee will education the clinical staff regarding foot care/nail care and the importance of routine podiatry visits by 4/9/2021. 4. The Educator/Designee will audit 6 residents a week for 4 weeks and then 3 residents a week for 8 weeks to ensure residents foot care needs are being met.	4/9/21

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F 687	Continued From page 29 coded to require extensive assistance of one staff with personal hygiene. During the initial tour on 2/23/21 at approximately 1:48 p.m., an interview was conducted with Resident #15. He was asked if he received toenail care. No response was made. He was then asked by the surveyor if she could see his feet. He stated, "Yes." The Resident's nurse, LPN (Licensed Practical Nurse) #1 was asked to assist in removing the covers from off of the Resident's feet. An observation of the resident's toenails revealed they were long, thick and curving into the skin on all of his digits/toes (both feet) except for the right and left great toe. LPN #1 stated that she will put him on the podiatry list. A review of progress notes revealed that Resident #15 was seen by a podiatrist on 8/16/20. Resident received Electrical and Mechanical debridement of nails. Dystrophic toenails were debrided digits 1-10. The Care Plan revealed the following: Resident has had a decline in ADL (Activity of Daily Living) ability secondary to recent hospitalization S/P fall. Goals: Resident will increase his level of independence in ADL'S by working with therapy and with assistance of staff will have ADL needs met through next review. Interventions: Let Resident know that you are there to assist him with his ADL'S. An interview was conducted on 02/25/21 at approximately, 9:56 AM with CNA (Certified Nurse's Aide) #1 concerning care of resident #15 toenails. She stated, "When we do ADL (Activities of Daily Living) care we check to see if they (Residents) need nail care then we let the nurse	F 687	The results of the audits will be reported quarterly at the QAPI meeting by the Educator/Designee for evaluation of compliance and ongoing monitoring for continuous improvement and analysis after the implementation. 5. All corrective actions will be completed by 4/9/2021.	

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know."

An interview was conducted on 2/25/21 at approximately, 10:45 a.m. with the DON (Director of Nursing) concerning podiatry services for Resident #15. She stated, "Our podiatry is coordinated through the Podiatrist. If we have a concern about a resident we will send it to him and he will add to that list. He comes monthly but can only bill quarterly. She was asked if facility RN's could have provided podiatry care to the residents? She stated, "Yes." "I just asked Resident #15 if he wanted podiatry care. He said yes."

The facility revised policy dated 02/2021 reads: Only a licensed nurse or podiatrist is allowed to cut the residents' toenails. CNA's are allowed to file the residents' toenails. Procedure: Cut or file the resident's toenails after bathing, if possible. Nails are soft and easy to trim after bathing.

On 2/25/21 at 3:35 p.m. a Debriefing was held with the Administrator and DON concerning the above issues with podiatry care services. No comments were voiced.

Onychomycosis: Fungus infection of the nail bed under the fingernails or toenails. Onychomycosis makes the nails look white and opaque, thickened, and brittle. It usually produces no symptoms other than a cosmetic problem.

Reference:
https://search.yahoo.com/yhs/search?hspart=pty&hsimp=yhs-pty_email&param2=91392702-4c31-4b0e-b504-1ff86be15a2c&param3=email_~US~appfocus1~&param4=d-ccc9-lp0-cp_6449161914ilc-bb8-iei-oth-su~MSIE~onychomycosis+definition

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F 687	Continued From page 31 ~D41D8CD98F00B204E9800998ECF8427E~Win10&param1=20191108&us_privacy=1---&p=onychomycosis+definition&type=em_appfocus1_ie www.rxlist.com/script/main/art.asp?articlekey=11766#:~:text=Onychomycosis%3A%20Fungus%20infection%20of%20the%20nail%20bed%20under,produces%20no%20symptoms%20other%20than%20a%20cosmetic%20problem. Dystrophic nails are nails that become misshapen, thickened, or have a partially destroyed nail plate. Nails may become distorted by too much keratin in the nail plate and nail bed, causing the nail to lift off the underlying skin. Dystrophic nails are commonly caused by a fungal infection of the toenail, called onychomycosis. Other potential causes include psoriasis and trauma - either direct injury or chronic, repetitive microtrauma. Reference: https://www.bergdpm.com/dystrophic-nails.html#:~:text=Dystrophic%20nails%20are%20commonly%20caused%20by%20a%20fungal,athlete%E2%80%99s%20foot%29%2C%20and%20less%20commonly%20yeasts%20or%20molds.	F 687		