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

PRINTED: 06/11/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496149	A. BUILDING _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

(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 A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health-Office of Licensure and Certification on 05/24/21 through 05/28/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000	This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies	
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 05/24/21 at 6:46 PM, the Administrator and Director of Nursing (DON) were notified of an immediate jeopardy at F919-L Resident Call System. The immediate jeopardy began on 05/17/21 when the facility became aware that the call system was not functioning. The facility provided an acceptable plan for removal of the immediate jeopardy on 05/26/21 at 10:51 AM. The removal plan included providing a metal handheld bell to all residents cognitively and physically capable of using it, assigned staff members to continually monitor the halls for residents ringing the bells and to check on each resident at least every hour, and in-serviced all staff on the plan in place until the call system can be repaired. The survey team validated the plan of removal and the immediate jeopardy was removed on 05/26/21 at 10:53 AM through observations, interviews, and review of Inservice records. The deficient practice remained at a	F 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa K Greer LNHA — TITLE: Interim Admin — (X6) DATE: 6/20/21

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

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F 000	Continued From page 1 lower scope and severity of an "F" after the removal of the immediate jeopardy. No deficiencies were issued related to intakes VA00050851 and/or VA00051529. Survey Dates: 05/24/21 - 05/28/21 Survey Census: 74 Sample Size: 18 Supplemental Residents: 0	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583	F583 1) The sign was removed from resident 50 room 2) Residents that reside in the facility are at risk for this deficient practice 3) A in-house audit was completed to ensure no other resident had signage posted in room. Licensed nursing staff have been re-educated by Clinical Manager on resident privacy. Hospice providers have been re-educated on resident privacy. DON/ designee will complete a random audit on selected rooms 3 x weekly x 30 days to ensure that no signage violating resident privacy is posted 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 583	Continued From page 2 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide privacy related to hospice care for one resident (Resident (R)50) out of total sample of 20 residents. Signage was posted above the bed stating R50 was receiving hospice care, including bathing, on Monday, Wednesday, and Friday. Findings Include: On 05/25/21 at 12:23 PM, observation revealed a sign above R50's bed stating "Hospice Days are Monday, Wednesday, and Friday. Hospice aide will do bath on those days." Review of the quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 10/19/20, revealed a "Brief Interview for Mental Status (BIMS)" score of eight out of 15 indicating moderately impaired cognitive status. Review of a quarterly MDS with an ARD of 04/28/21 revealed R50 was receiving hospice care. On 05/26/21 at 10:10 AM, interview with Unit Manager 2 revealed that she did not know that Hospice signage was above the resident's bed. Unit Manager 2 went into R50's room and removed the sign above R50's bed. Unit Manager	F 583		

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F 583	Continued From page 3 # stated that the sign never should have been on the wall.	F 583		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section-	F 645	F645 1) Residents #8, #51 and #53 have had a level II PASARR screening completed and or in progress 2) Social Services completed an audit of residents residing in facility to ensure a PASARR level II has been completed on residents that indicate a need for level II PASARR. 3) Social Services were re-educated by Administrator on process to ensure residents are reviewed for level II PASARR A random audit will be completed by Social Services/ designee on new admissions 2x week x 30 days to ensure that new admissions indicating the need for a level II PASARR have one completed timely. 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 645	Continued From page 4 (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a level II "Preadmission Screen and Resident Review (PASARR)" screening for three residents (Resident (R) 8, R51, and R33) reviewed out of 20 sampled residents. Level II PASARR screenings are	F 645		

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F 645	Continued From page 5 required for individuals with serious mental disorders to determine the need for specialized services. Findings include: 1. Review of R8's undated "Diagnosis" tab in the electronic medical record (EMR) revealed diagnoses which included Major Depressive disorder, Unspecified psychosis not due to a substance or known physiological condition, and anxiety disorder. Review of a document titled "Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions" located in the miscellaneous tab of the EMR, signed and dated 02/26/19, revealed a recommendation for a referral for a secondary assessment/level II Preadmission Screen and Resident Review (PASARR). The medical record was reviewed in its entirety and was silent for a secondary assessment/ level II PASARR. During an interview on 05/27/21 at 11:00 AM, Social Service Aide (SSA) 1 stated that a level II PASARR had never been completed for R8. SSA1 stated she contacted the company that completes the level II PASARRs and was told they had not received the needed paperwork to complete the process. Review of a faxed document revealed SSA1 submitted the paperwork for R8 on 05/26/21 at 5:07 PM. 2. Review of R51's undated "Diagnosis" tab in the electronic medical record (EMR) revealed diagnoses included schizophrenia, bipolar	F 645		

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F 645	Continued From page 6 disorder, unspecified dementia with behavioral disturbance, major depressive disorder, and generalized anxiety disorder. Review of a document titled "Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions" located in the miscellaneous tab of the EMR, signed and dated 02/28/19, revealed a recommendation was made for a referral for a secondary assessment/level II Preadmission Screen and Resident Review (PASARR). The medical record was reviewed in its entirety and was silent for a secondary assessment/level II PASARR. During an interview on 05/27/21 at 11:00 AM, Social Service Aide (SSA) 1 stated that a level II PASARR had never been completed for R51. SSA1 stated she contacted the company that completes the level II PASARRs and was told they had not received the needed paperwork to complete the process. Review of a faxed document revealed SSA1 submitted the paperwork for R51 on 05/26/21 at 3:46 PM. 3. Review of R33's undated "Face Sheet," located in the electronic medical record (EMR) under demographics, revealed R33 was admitted on 07/31/18 with diagnoses including major depressive disorder, bipolar II disorder, and schizoaffective disorder. Review of R33's quarterly "Minimum Data Set	F 645		

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F 645	Continued From page 7 (MDS)" with an Assessment Reference Date (ARD) of 03/18/21 revealed R33 had not been evaluated for a Level II PASARR. Further review indicated R33's "Brief Interview for Mental Status (BIMS)" score was a 15 out of 15 indicating the resident is cognitively intact and has psychiatric/mood disorders including anxiety, depression, manic depression (bipolar) and schizophrenia. Review of R33's PASARR level I, dated 02/28/19 and located in the paper medical record, revealed "...recommendation...refer for secondary assessment.(NF [nursing facility] placement=Level II refer to [name of organization].)" During an interview on 05/27/21 at 3:48 PM, the Social Services Assistant (SSA) confirmed that R33's recommended Level II PASRR had not been completed. The SSA stated, "the PASRR II should be completed within 7 days of recommendation for Level II." Review of the facility's policy titled "Preadmission Screening and Resident Review (PASRR)," dated 03/01/19, revealed " . . . The facility's social services director (or social services designee) will be the primary person responsible for completing the Level I screening. Any individual identified as needing a Level II evaluation must be referred to the following level II evaluator . . . "	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		

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F 657	Continued From page 8 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure one resident's plan of care was revised for code status. This involved one resident (Resident (R) 54) of 20 sampled residents. Findings include: Review of R 54's Advance Directive, located in the paper chart and signed by his guardian and dated 05/17/21, revealed R54 was a full code status and was to receive cardiopulmonary resuscitation (CPR) if found without a pulse	F 657	F657 1) The care plan was updated for Resident #54 to accurately reflect his current Advance Directive of being a full-code status 2) Residents that reside in the facility are at risk for this deficient practice 3) Social Services and Licensed Nursing staff were re-educated on updating care plans to reflect residents current status. MDS/designee will complete a random audit of 5 care plans weekly x 30 days to ensure care plans are being updated to reflect residents current status 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 657	Continued From page 9 and/or not breathing. Review of R54's physician's "Orders," located in the orders tab of the electronic medical record (EMR) revealed a physician's order, dated 05/25/21, for a full code. Review of R54's "Care Plan," located in the care plan tab of the EMR and initiated on 01/22/18, stated R54 was a "do not resuscitate (DNR)" meaning CPR would not be initiated if found without a pulse and/or not breathing. Review of R54's previous Advance Directive, signed and dated 02/24/18, revealed R54's code status was "do not resuscitate." The Advance Directive signed by his legal guardian on 05/17/21 changed the directive to a full code. On 05/25/21 at 5:00 PM, the "Minimum Data Set (MDS)" nurse verified the care plan was not revised when R54's code status changed from DNR to a full code on 05/17/21.	F 657		
F 686 SS=G	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	F 686	F686 1) Resident #68 continues to received wound care by the WCP and WCN. Preventative measures are in place to avoid further skin breakdown for this resident. 2) An audit was completed by the DON and WCN to identify residents at risk for skin breakdown. A skin sweep was completed on these residents identified to be at risk. 3) Licensed nursing staff and CNAs were re-educated on preventing skin breakdown. This included skin observation during care, weekly head to toe assessments, interventions and the Braden scale. The DON/ designee will randomly audit 10 residents weekly x 30 days to ensure the weekly head to toe assessments are being completed timely and accurately. 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 686	Continued From page 10 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide care and services to prevent the development of a pressure ulcer in one of four residents (Resident (R) 69) reviewed for pressure ulcers in a total sample of 20 residents. The failure to provide care and services resulted in the development of a deep tissue injury (DTI) and a Stage III pressure ulcer to R69's left foot which constitutes harm. Findings include: Review of R69's undated "Face Sheet" located in the electronic medical record (EMR) under demographic tab, revealed R69 was admitted on 06/19/20 with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (partial loss of strength on one side) following cerebral infarction (stroke), muscle weakness, and contracture (rigidity and deformity of a joint) of muscle, multiple sites. R69 was discharged to an acute care facility (hospital) on 02/02/21 and readmitted to the facility on 02/05/21. Review of R69's quarterly "Minimum Data Set (MDS") with an Assessment Reference Date (ARD) of 05/07/21 revealed a "Brief Interview of Mental Status (BIMS)" score of 10 indicating R69 is moderately cognitively impaired. Further review of the MDS revealed R69 is dependent on staff for all ADLs requiring extensive assistance. Review of the undated "Care Plan," located in the	F 686		

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F 686	Continued From page 11 EMR under the care plan tab, revealed R69 "has a physical functioning deficit related to generalized weakness, impaired mobility and cognition and left hemiplegia, requires extensive to total assistance for all activities of daily living (ADLs) . . . interventions: . . . assistive devices as needed, bed mobility assistance assist times two, dressing assistance as needed . . . personal hygiene assistance as needed, turning and positioning, assist resident two person." Review of the undated "Care Plan," located in the EMR under the care plan tab, revealed no care plan addressing R69's contractures. Review of R69's EMR revealed no documentation of staff consistently turning and repositioning R69 during March 2021, April 2021, and/or May 2021. Request for documentation of R69 being repositioned was made on 05/27/21 at 2:30 PM, from the Director of Nursing (DON). The DON reported on 05/27/21 at 3:27 PM she was unable to locate any documentation. Review of R69's "Physician's Order Audit Report" located in the orders tab of the EMR, revealed on 09/22/20, R69 had orders for a left-hand resting splint that was discontinued when the resident was discharged to the hospital on 02/02/21. Review of R69's orders revealed these orders for the hand splint were not reinitiated upon R69's readmission on 02/05/21. Further review of the physician orders revealed no orders for leg or foot contractures. Review of R69's "Physician Orders," dated 05/09/21, located in the EMR under the orders tab, revealed "wound care orders: Triad Hydrophilic wound dress paste (wound dressing)	F 686		

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

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OMB NO. 0938-0391

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F 686	Continued From page 13 apply padding to the bony areas, we'll work on a plan." Observation conducted during the survey on 05/24/21, 05/25/21, and 05/26/21, revealed R69's left lower extremity curled in a fetal position with the right lower leg and foot laying on top of the left foot pressing it into the mattress. There was no padding on the left foot, between the foot and mattress or the right lower extremity. Review of the medical record revealed no treatment orders for the pressure ulcer were obtained prior to the assessment by the WCP on 05/28/21. During an interview conducted with CNA 4 on 05/27/21 at 1:30 PM, CNA 4 was asked how often does she turn the residents? CNA 4 stated, "we try to turn them every two to three hours." During an interview on 05/27/21 at 2:15 PM, the DON was questioned what her expectations were of staff when it comes to repositioning residents? The DON stated her expectations are for the staff to turn the residents every three hours and as needed. Review of the facility's policy titled "Wound Prevention Program," dated 08/2019, "Pressure sore Prevention-Quick Look ...protect skin against friction and shearing forces, avoid massage over bony prominences ...turn and reposition at least every 2 hours in bed ...active or passive range of motion for bed ridden residents to optimize the perfusion of peripheral capillary vessels, use pressure redistribution device and/or positioning device, relieve heel pressure, use heel/elbow protectors as appropriate, and use	F 686		

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F 686	Continued From page 12 ...apply to sacrum topically every shift for stage II [pressure ulcer] ..." During R69's wound care observation on 05/28/21 at 12:37 PM, accompanied by the wound care nurse (WCN) and wound care physician (WCP), it was discovered R69 did not currently have a sacral pressure ulcer but had a pressure ulcer on the left foot which was not documented on the undated "pressure ulcer actual" care plan. During an interview on 05/28/21 at 12:37 PM at R69's bedside, the WCP stated, " I was notified by the facility by telemed last Saturday (05/22/21) about a new wound on the resident's foot." The WCP stated that on 05/28/21 the facility had shown a picture of the pressure ulcer on R69's foot. The WCP stated that the facility was advised the pressure ulcer would be assessed further on 05/28/21. The WCP stated after seeing the picture of the pressure ulcer, "I didn't realize it [pressure ulcer] was that bad." During the wound observation on 05/28/21 at 12:37 PM, the WCP noted on the left distal medial [inner] foot a pressure ulcer that measured 5.5 centimeters(cm) by 2.9 cm and staged the wound as deep tissue injury (DTI-pressure injury deep into tissues under intact skin).The WCP noted on the left lateral [outer] distal foot pressure ulcer that measured 3.8 cm by 2.2 cm and 0.3 cm depth and staged as a stage III (full thickness loss down to subcutaneous tissue) pressure ulcer. The WCP was questioned if these wounds could have been avoided since the resident's lower extremities are severely contracted? The WCP stated, "yes, the staff would need to reposition frequently and	F 686		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 14 protective clothing for fragile skin."	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of facility policy, the facility failed to provide treatment to maintain and/or prevent decrease in range of motion (ROM), including the provision of equipment for limited range of mobility, for three out of three residents (Resident (R) 32, R45, and R69) reviewed for ROM/splints out of a sample of 20. Specifically, the facility failed to: 1. Provide an evaluation and treatment to R32's contracture of the right hand; 2. Provide care and services for R45's upper and lower extremities; and 3. Continue services for R69, including application of splints, after readmission to the facility. This failure has the	F 688	F688 1) Residents #32 has had an evaluation/ treatment for the contracture of the Right hand. Resident #45 is receiving care and services for upper and lower extremities and Resident #69 will receive application of splints after returning to the facility. 2) Therapy and DON completed an audit to identify residents with limited ROM to ensure any needs for treatment were addressed. 3) Nursing staff were re-educated by Therapy and the DON on care of residents with limited ROM and the importance of performing ROM and applying splints and or devices as indicated. Therapy or designee will complete an audit 3x week x 30 days to ensure that residents with identified treatments for ROM are receiving the treatments as ordered 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 688	Continued From page 15 potential to adversely affect the range of motion to each residents' contracted extremities. Findings include: Review of the facility's policy, provided by the facility as their ROM policy, titled "Section 4, Range of Motion," training module from the "2017 Restorative Nursing Manual," documented "range of motion rationale...to counteract negative effects of immobility and disuse." 1. Review of R32's undated "Face Sheet," located in the electronic medical record (EMR) under the demographics tab, revealed R32 was admitted to the facility on 12/15/20. R32's diagnoses included hemiplegia (paralysis on one side) and hemiparesis (weakness on one side) following a cerebral infarction (stroke) affecting right dominant side, aphasia (difficulty speaking), and peripheral vascular disease (poor blood circulation to the extremities). Review of R32's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/21/20 revealed no documentation of R32's contracture or of any services for the contracture. Review of R32's undated "Care Plan" located in the EMR under the care plan tab, revealed no care plan, physical therapy (PT)/occupational therapy (OT) and/or no nursing interventions related to R32's right hand and/or left leg contracture. Review of R32's "Treatment Administration Record(TAR)" located in the EMR under the orders tab, for the months of January, February.	F 688		

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F 688	Continued From page 16 March, April, and May 2021 revealed no ROM (range of motion) documented as being performed. Observations conducted on 05/24/21 at 10:30 AM, 05/25/21 at 12:30 PM, and 05/26/21 at 1:30 PM revealed R32 had no splint to his right hand. R32 is unable to move his right hand having to pick it up with his left hand. Observation of R32's right hand revealed his hand is in a clenched position, without a splint or washcloth in his palm. Resident is unable to open his right hand independently. During an interview and observation on 05/27/21 at 2:42 PM, the Unit Manager (UM) 2 stated she was not sure if R32 had a splint, receives rehabilitation, and/or passive range of motion (PROM-movement applied to a joint solely by another person). During an interview on 05/27/21 at 4:18 PM, the Director of Rehabilitative Services (DRS) stated she had not evaluated R32 for contractures. During an interview on 05/28/21 at 9:30 AM, the DRS provided written recommendations for R32 for "Rehab[ilitation] to screen for OT[occupational therapy]/physical therapy]/PT and if therapy is warranted, request therapy through [name of insurance]. The DRS also recommended nursing to "Turn and reposition every two hours." The DRS was asked why had R32 not been evaluated for therapy services on admission? The DRS responded, "because he had not been referred by the nursing staff for an evaluation." 2. Review of R45's undated "Face Sheet," located in the R45's electronic medical record (EMR)	F 688		

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F 688	Continued From page 17 under the demographics tab, revealed R45 was admitted to the facility on 02/08/20. R45's diagnoses included cerebral infarction (stroke) due to embolism (blood clot), hemiplegia (paralysis on one side) affecting left nondominant side and dysphagia (difficulty swallowing) following a cerebral infarction (stroke). Review of R45's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/02/21, revealed no current rehabilitation services and/or range of motion and no documentation of contractures. Review of this MDS revealed a "Brief Interview for Mental Status (BIMS)" of 14 out of 15 indicating R45 is cognitively intact. Review of R45's undated "Care Plan," located in R45's EMR under the care plan tab, revealed care plan with interventions related to R45's LUE (left upper extremity) and/or LLE (left lower extremity) contractures. Review of R45's "Treatment Administration Record (TAR)," located in the EMR under orders tab, for the months of January, February, March, April, and May 2021 revealed no ROM exercises provided. Review of the "Orders," located in the EMR under the orders tab and dated May 2021, revealed no physicians orders for ROM. Observations on 05/24/21 at 11:00 AM, 05/25/21 at 12:00 PM, and 05/26/21 at 1:45 PM revealed R45's LUE and LLE contractures did not have any devices in place to prevent further contracture of the joints. During an interview on 05/24/21 at 11:42 AM, R45 verified there were no devices in place for the	F 688		

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F 688	Continued From page 18 contractures of her left arm or left leg. R45 stated, "insurance does not pay for physical therapy." R45 was asked if the nursing staff provides range of motion exercises to her contractures. R45 stated, "some of the nursing staff does it [ROM] but not all." During an interview on 05/27/21 at 2:42 PM, Unit Manager (UM) 2 verified that R45 had no devices in place for the left hand and left leg contractures. UM2 was unsure if R45 had a physician's order for a splint or if R45 received therapy and/or ROM exercises. During an interview on 05/27/21 at 4:10 PM, the Director of Rehab Services (DRS) stated, "the resident has no means for rehab to be covered. [R45's insurance] does not cover these services." During an interview on 05/28/21 at 9:32 AM, the DRS provided documentation indicating "rehab to screen again due to a change in her condition, and if therapy is warranted, request therapy for OT/PT through [R45's insurance] notification. Recommendations for nursing staff: hand hygiene daily, proper positioning for self-feeding with dominant hand, get patient up in wheelchair daily, up to two hours a day." 3. Review of R69's undated "Face Sheet" located in the electronic medical record (EMR) under the demographic tab, revealed R69 was admitted to the facility on 12/31/17. R69's diagnoses included hemiplegia (paralysis on one side) and hemiparesis (weakness on one side) following a cerebral infarction (stroke) affecting left non-dominant side, muscle weakness, and contracture of muscle (rigidity and deformity of a joint), multiple sites.	F 688		

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F 688	Continued From page 19 Review of R69's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/07/21 revealed R69 was not receiving restorative nursing such as range of motion (passive or active) or splint or brace and no documentation that R69 had contractures. Review of R69's undated "Care Plan," located in the EMR under the care plan tab, revealed interventions of a left-hand resting splint and for the staff to perform "gentle ROM [range of motion exercises] to the left hand ... and apply left-hand splint as ordered." Review of R69's "Treatment Administration Record (TAR)," located in the EMR under the orders tab, for the months of January, February, March, April, and May 2021 revealed no ROM exercises documented as being provided by staff. During an interview on 05/27/21 at 2:39 PM, Unit Manager (UM) 2 stated she is "not sure where the resident's splint is or if nursing does ROM." UM2 verified that R69 has a left-hand contracture. During an interview on 05/27/21 at 4:02 PM, the Director of Rehab Services (DRS) indicated on 09/22/20 R69 had" hand splints, ordered a resting hand splint due to pain, active range of motion, and positioning. Goals were not met due to pain." On 06/23/20 rehab started passive range of motion (exercises done by staff) and expected nursing staff to continue." The DRS stated R69 "has had splints in the past but don't know where they go." During an interview on 05/28/21 at 9:15 AM, the DRS provided documented recommendations	F 688		

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F 688	Continued From page 20 dated 05/28/21 for "rehab to screen again since she has had a change since last seen for OT services ...recommendations for nursing staff: she needs to get up out of bed (OOB) daily, hand hygiene daily. She was refusing in the past due to pain recommend consult with pain management, recommend palm guard to left hand to keep from breaking down and to help with contractures, and position her as upright as possible for meals."	F 688		
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. §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	F 756	F756 1) Residents #49 and #54 pharmacy recommendations have been addressed by the physician 2) Any Residents receiving pharmacy recommendations are at risk for this deficient practice 3) Licensed nursing staff, clinical managers, NP and physicians were re-educated by the DON/designee on the appropriate process for addressing pharmacy recommendations. An audit will be completed by the DON/designee monthly x 2 months to randomly check 5 pharmacy recommendations for appropriate response by the physician/designee 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 756	Continued From page 21 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 record review and staff interview, the facility failed to ensure the attending physician reviewed recommendations, documented in the medical record that recommendations were reviewed, and documented rationale for not acting on the recommendations made by the pharmacist during monthly medication regimen reviews (MRR) for two of five residents (Resident (R) 49 and R54) reviewed for unnecessary medications. Findings include: Review of the undated policy titled "Medication Monitoring - Medication Regimen Review and Reporting" revealed it was the facility policy for pharmacy recommendations to be acted on in 30 days. On 05/27/21 at 4:30 PM, pharmacy recommendations with the physician responses were requested from the Director of Nursing (DON). On 05/28/21 at 10:30 AM, the Regional Clinical Director stated they were unable to find any responses to the pharmacist's MRRs for R49 and R54.	F 756		

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F 756	Continued From page 22 Review of the pharmacy reports revealed the following: 1. Review of pharmacy reports for R54 revealed the following: A pharmacy MRR report titled "PharMerica," dated 12/18/20, revealed the pharmacist recommended the physician add a stop order to the Clonazepam (medication to treat anxiety) as needed (PRN) order. At the bottom of the report was an area for the physician to document their recommendation and sign. The bottom of the form was not completed or signed by the physician. A pharmacy MRR report titled "PharMerica," dated 02/16/21, revealed a recommendation to discontinue Clonazepam PRN after 14 days or after 60 days with an explanation. The bottom of the report was not completed as the physician did not sign the form or make a recommendation. Review of the R54's current and discontinued physician's "Orders," in the orders tab of the electronic medical record (EMR) revealed a physician's order for Clonazepam tablet 0.5 MG (milligram) one tablet every 8 hours as needed for anxiety related to major Depressive Disorder Recurrent Moderate, One tablet three times daily PRN for anxiety with a maximum daily dose of 1.5 mg. The order had a start date of 10/19/20 and an end date of 05/12/21. The medical record was reviewed and was silent to the physician reviewing and acting on the recommendations. A pharmacy MRR report titled "PharMerica," dated 01/23/21, revealed the pharmacist	F 756		

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

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FORM APPROVED
OMB NO. 0938-0391

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	496149	A. BUILDING _____ B. WING _____	C 05/28/2021

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F 756	Continued From page 23 recommended considering decreasing Pantoprazole (treats reflux disease) 40 mg AC (before meals) and HS (at bedtime) to every morning before breakfast only and at bedtime to reduce the risk of adverse effects. The MRR was not signed by the physician and the physician did not respond to the recommendation. Review of the physician's "Orders," located in the orders tab of the EMR revealed R54's order for Pantoprazole Sodium Tablet delayed release was not decreased and remained the same from 10/20/20 to 05/13/21. 2. Review of pharmacy reports for R49 revealed the following: Review of R49's MRR, dated 04/20/21, revealed R49 had a physician's order for Restoril (medication to treat insomnia) 7.5 mg (milligram) HS (at bedtime) and Zoloft (antidepressant) 50 mg every day (QD). The pharmacist recommended the physician evaluate the use of the medications to see if a reduction could be attempted. There was no physician response on the form nor signature. Review of the physician's "Orders," located in the orders tab of the EMR, revealed R49 had a current order for Restoril Capsule 7.5 mg give one capsule by mouth for insomnia with a start date of 12/09/20. Review of the physician's orders revealed R49 had a current order for Zoloft 50 mg give one time a day for inconsolable crying related to major depressive disorder recurrent with a start date of 09/23/20. The orders remained unchanged and there was no documentation in the medical record to indicate the pharmacy recommendation was acted upon.	F 756		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §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	F 758	F758 1) Resident #24 has been evaluated for a gradual dose reduction 2) Residents on Psychotropic medications are at risk for this deficient practice 3) Licensed Nursing staff were re-educated by the DON/designee on gradual dose reductions and pharmacy recommendations. The DON/designee will audit 4 residents with Psychotropics weekly x 30 days. The weekly chemical restraint meeting will monitor one category weekly x 30 days to ensure consideration is made for reduction on residents medication. 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th , 2021	

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F 758	Continued From page 25 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 record review, pharmacy and nurse practitioner interview, and policy review, the facility failed to attempt a gradual dose reduction (GDR) for one of five residents (Resident (R)24) reviewed for unnecessary medications in a total sample of 20 residents. Findings include: Review of the "Face Sheet," dated 05/05/17, revealed R24 was admitted to the facility on 05/05/17 and had current diagnoses which included dementia with behavioral disturbance, unspecified psychosis, and major depressive disorder. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/05/21 revealed a "Brief Interview for Mental Status (BIMS)" of 11 out of 15 indicating moderate cognitive impairment. Further review of this MDS revealed no behaviors, no delusions, or hallucinations were documented for R24. During an interview on 05/27/21 at 11:21 AM, the Consultant Pharmacist revealed that a pharmacy recommendation was made for a gradual dose reduction (GDR) attempt for Seroquel	F 758		

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F 758	Continued From page 26 (antipsychotic medication), Lexapro (antidepressant), and Buspar (antidepressant). Review of a medication regimen review (MRR), dated 03/21/21 and located in the EMR under the MRR tab, revealed that the physician disagreed with the dose reduction. Further review of the pharmacy recommendation on the MRR revealed the Director of Nursing (DON) signed the declination as a verbal order from the Nurse Practitioner (NP) and to continue current doses of Seroquel, Lexapro, and Buspar. During an interview on 05/27/21 at 2:02 PM, the NP revealed when asked her rationale for not attempting a GDR on an elderly resident with the diagnosis of dementia the NP stated that she did not remember giving the DON a verbal order. Review of the EMR under the pharmacy tab revealed the last dose reduction was done on 11/09/20. Review of the EMR "Orders" revealed physician orders, located under the orders tab and dated 03/21/21, for Lexapro 10 mg po daily for anxiety, Seroquel 50 mg in the evening for psychosis, BuSpar 5mg po bid for anxiety. Review of a Psychiatric Evaluation, dated 05/11/21 and located in the EMR under the orders tab, stated that R24 was not exhibiting recent mania, aggression, or agitation and no recent behavioral changes or psychiatric concerns. Review of the "Care Plan," located in the EMR under the care plan tab and dated 03/28/21, revealed to "continue medications as prescribed, the patient is stable at current dose."	F 758		

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F 758	Continued From page 27 A policy on Gradual Dose Reductions (GDR) was requested throughout the survey. The following was provided as a policy for GDRs. Review of the facility's policy titled: "Chemical Restraint," revision date of 10/2019 states ... Drug reviews will be conducted monthly by the pharmacist and communicated to the attending physician with recommendations to either reduce or eliminate drug usage as appropriate.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761	F761 1) The Unit 1 medication room has been cleaned out so there are no expired medications or equipment in them 2) An audit was completed on medication rooms on Unit 1 and 2 to ensure medications and equipment were not expired 3) Licensed nursing staff and central supply person were re-educated by the DON/Designee on keeping the Unit medication rooms stocked with medications and equipment that is not expired, rotating stock and monitoring supplies for expiration dates Unit managers/designee will completed an audit of medication rooms 3x week x 60 days to ensure all supplies and medications have not expired 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and policy review, the facility failed to ensure that all medicines and equipment in one of two medication storage rooms were not expired or opened. Findings include: Review of the policy "Medication Storage," dated 2007, revealed " ... outdated, contaminated, discontinued or deteriorated medications and those in container that are cracked, soiled, or without secure closures are immediately removed from stock, and disposed of . . . " On 05/27/21 at 4:24 PM, Unit 1 Medication Storage Room was inventoried. The following items were found to be outdated: Magnesium Citrate (laxative) 10 FL. Oz. with an expiration date of 2/2021. Sore Throat Spray 6 FL. Oz. with an expiration date of 2/2021. Vial 2 Bag DC 20mm. with an expiration date of 6/1/2020. A vial2bag device enables reconstitution and transfer of a drug between a vial and an IV bag. One opened oxygen connector was found opened in a drawer with no labeling or covering. One Kangaroo Pump container that was opened. On 05/27/21 at 4:50 PM, Unit Manager 2 was asked to come into the Unit 1 Medication Storage Room and check the expiration dates on the above outdated items. Unit Manager 2 confirmed that the magnesium citrate, sore throat spray, vial 2 Bag DC, oxygen connector, and Kangaroo pump container were outdated and/or opened.	F 761		

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F 761	Continued From page 29 Unit Manager 2 removed the opened items and outdated medicines from the room.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, menu review; and staff interview, the facility failed to follow the menus during lunch service on 05/26/21. The facility failed to serve residents a full portion of the garlic and rosemary roasted red skin potatoes, the	F 803 F803	1) The kitchen is serving meals per the posted menu and Resident #1 is receiving his meals per his ordered diet 2) Residents receiving meals from the kitchen are at risk for this deficient practice 3) The kitchen manager and staff were re-educated by the dietician/designee on the importance and process of following the posted menu, following speciality diets and resident preferences. The administrator/designee will audit 6 meals a week x 30 days to ensure. The menus and specialty diets are being followed 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 803	Continued From page 30 sauteed zucchini, and the baked macaroni and cheese and failed to follow the renal menu for one resident (Resident (R)1). This failure involved 20 of the 67 residents who receive food from the facility dietary department. Findings include: On 05/26/21 from 12:05 PM through 1:26 PM, Cook 2 was observed serving lunch from a steam table in the kitchen. Review of the menu revealed residents on regular diets and concentrated carbohydrate diets were supposed to receive a ½ cup (4 ounces) serving of sauteed zucchini and ½ cup (4 ounces) of garlic and rosemary roasted red skin potatoes, one Italian sausage, a dinner roll, and a lemon bar. Further review of the menu revealed residents on renal diets (residents with kidney disease) were supposed to receive a 3-ounce parsley pork chop, ½ cup of sauteed zucchini, ½ cup garlic mashed potatoes, a dinner roll, and a lemon bar. The alternative for the Italian sausage was one cup of baked macaroni and cheese. During this observation on 05/26/21, Cook 2 was observed filling the 4-ounce scoop halfway when serving the zucchini and red skin potatoes. Cook 2 did not give 15 of the residents a full 4-ounce scoop of the food items per the menu. In addition, four residents who had macaroni and cheese listed on the menu slip received one four-ounce (half a cup) scoop and not one cup per the menu. On 05/26/21 at 12:26 PM, Cook 2 was ask why she was not completely filling the scoop. Cook 2 did not respond but then began completely filling the scoop. On 05/26/21 at 1:00 PM, Cook 2 ran out of sauteed zucchini. The Food Service Supervisor and District Manager of Healthcare	F 803		

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F 803	Continued From page 31 Services (the contract foodservice company used by the facility) had to prepare more zucchini for the last nine residents waiting to be served lunch. On 05/26/21 at 12:57 PM, Cook 2 plated a renal diet lunch tray for R1. Cook 2 plated the garlic and rosemary roasted red skin potatoes when the menu stated renal diets were supposed to receive garlic mashed potatoes. When Cook 2 was ask about it she stated she made a mistake and took the plate back and served R1 the garlic mashed potatoes. Review of the physician's "Orders," located in the orders tab of the electronic medical record (EMR) revealed R1 had an order for "Renal diet, Dysphagia Advanced texture related to CHRONIC KIDNEY DISEASE, STAGE 5," with a start date of 08/08/19. Review of R1's "Diagnoses," located in the diagnosis tab in the EMR, revealed diagnoses which included chronic kidney disease stage 5 (CKD 5). Review of the "Care Plan," located in the care plan tab of the EMR, revealed R1 had a plan of care for diet alteration related to CKD 5 and dysphagia (difficulty swallowing) with a revision date of 05/30/19. An intervention for this care plan was "diet as ordered." On 05/26/21 at 1:39 PM, the District Manager verified that Cook 2 was not filling the scoop up all the way when she was serving. The District Manager stated Cook 2 should have made enough food for everyone prior to the beginning of the meal service.	F 803		

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F 803	Continued From page 32 During confidential resident interviews two residents on Unit two stated the portions are small and sometimes they do not get enough food on their plate. Review of the resident matrix with a print date of 05/21/21 and the "Resident Census and Condition of Residents" (Form CMS-672) signed by the MDS Nurse and dated 05/28/21 revealed seven of the facility's 74 residents received tube feedings. Therefore 67 residents receive food from the facility kitchen.	F 803		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and policy review, the facility failed to ensure food was	F 812	F812 1) Staff is serving food in a sanitary manner with gloves being changed and hands being washed between touching soiled areas and. Serving and preparing food. Food carts have been cleaned and sanitized and sanitizing solution in the third sink is at appropriate levels 2) Residents that reside in facility are at risk for this deficient practice 3) Kitchen staff were re-educated by the Dietary manager/ Designee regarding sanitary food service practices, cleaning equipment and appropriate levels and testing of sanitizer solution. The administrator/designee will audit the kitchen 2x week x 30 days for sanitation and cleanliness. 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 812	Continued From page 33 prepared and served in a sanitary manner. This involved failure to change gloves and/or wash hand between touching soiled dishes and touching clean dishes; failure to ensure sanitizing solution was at the proper level to sanitize food contact surfaces, pans, and serving utensils; failure to ensure food carts were cleaned and sanitized after transporting soiled dishes and before placing resident meal trays in them. This had the potential to affect all 67 residents in the facility who receive food from the dietary department. Findings include: Review of the resident matrix with a print date of 05/21/21 and the "Resident Census and Condition of Residents" (Form CMS-672) signed by the "Minimum Data Set (MDS)" nurse and dated 05/28/21 revealed seven of the facility's 74 residents received tube feedings. Therefore 67 residents receive food from the facility kitchen. 1. On 05/24/21 at 9:31 AM, Dietary Aide 1 (DA1) was observed wearing gloves while placing soiled plates on the dishwashing racks. After running the plates through the dishwasher, DA1 went to the clean end of the dishwasher and removed the clean plates while wearing the same soiled gloves. With the same gloves, DA1 placed soiled thermal plate holders and metal plate pellets on a dishwashing rack and washed them in the dishwasher. DA1 took a trash can outside and returned with the trash can wearing the same gloves. DA1 removed the clean rack of thermal plate holders and metal plate pellets from the dishwasher and removed them from the rack and placed them on a clean cart without first changing her gloves and washing her hands. DA1 then ran	F 812		

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

PRINTED: 06/11/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495149	A. BUILDING _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 34 a second rack of dirty plates through the dishwasher and returned to the clean end and again removed the clean plates without changing her gloves and washing her hands. On 05/24/21 at 9:42 AM, DA1 was ask what the procedure was for going from the soiled end of the dishwasher to the clean end and she stated she was supposed to remove her gloves, wash her hands, and place clean gloves on. When she was told she was witnessed not washing her hands she admitted she had not changed her gloves or washed her hands between the soiled and clean side of the dishwasher. On 05/24/21 at 10:15 AM, a policy for running the dishwasher and hand washing in the dietary department was requested. No policy was provided related to handwashing and changing gloves when washing resident dishes in the dishwasher. 2. On 05/24/21 at 9:30 AM, Dietary Aide 2 (DA2) was observed using a wiping cloth from a red container to sanitize the food preparation counters. DA2 stated it was sanitizing solution. On 05/24/21 at 9:46 AM, the sanitizer levels of the third compartment of the three-compartment sink and two red containers used to store wiping cloths for food contact surfaces were checked with the assistance of Cook 1. The sanitizer compartment of the three-compartment sink contained two serving ladles and a serving fork at the time the sanitizer level was checked. The sanitizer measured zero parts per million (ppm). Both red containers of sanitizing solution also measured zero ppm. DA2 verified she had used one of the containers to "sanitize" the food preparation counters. A container of Oasis 146 Multi-Quat Sanitizer was hanging on the wall	F 812		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 35 above the three-compartment sink. Cook 1 stated it was the sanitizer used to sanitize pots, pans, and utensils and to fill the red containers used to sanitize food preparation surfaces and equipment. Review of the Manufacture's instructions for the "Oasis Multi-Quat Sanitizer" revealed the Multi-Quat Sanitizer was required to be 150 to 400 ppm to sanitize. 3. On 05/24/21 at 9:56 AM, a cart containing pans stacked together was located next to the stove. Cook 1 stated the pans had already been washed and were clean. Two of four pans inspected had dried food substances on the inside surface of the pans. Cook 1 verified the pans had not been thoroughly cleaned. 4. On 05/26/21 at 12:19 PM, after the staff began placing resident food trays in the first food cart the District Manager for Healthcare Services (the contract food service company used by the facility) was ask if all the carts had been cleaned and were ready for the food trays to be placed in to be delivered to the residents. The District Manager stated the carts had been cleaned. The carts were inspected with the District Manager for Healthcare Services. Inspection of the carts revealed each of the carts were soiled with dried food residue on the inside corners, bottom, sides, and doors. In addition, brown fluid was in the bottom of the two large, insulated food carts. The District Manager verified the carts remained soiled from when the soiled breakfast dishes were returned to the kitchen. The District Manager verified the carts appeared as if they had not been cleaned in a while.	F 812		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 36 Review of the "Healthcare Services Group, Inc policy 027" titled "Equipment," with a revised date of 09/2017, revealed it was the facility policy to clean and sanitize equipment and food contact surfaces after each use. Review of the undated "Service Line Checklist" revealed food carts were to be cleaned after each meal.	F 812		
F 880 SS=E	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 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	F 880	F880 1) Licensed staff clean glucometers per manufacturer recommendations and place barrier down when using a cleaned glucometer 2) Residents that receive accuchecks are at risk for this deficient practice. 3) Licensed nursing staff were re-educated by the DON/designee on infection control practices for cleaning and utilizing glucometers. The DON/designee will randomly audit Glucometer usage for 3 residents 2x week x 30 days 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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

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F 880	Continued From page 37 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 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 observation, interview, record review, review of policies and procedures, and review of	F 880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 38 medical device and product user information, the facility failed to ensure the nursing staff used a barrier between surfaces and cleaned and disinfected multi-use glucometers per the manufacturer's instructions when performing fingerstick blood glucose monitoring in three of three nurses observed. Findings include: Review of the "Summary Report of Meeting for Infection Control," dated March 21, 2021, revealed an inservice on the procedure on how to disinfect multi-use glucometers. The inservice instructed the nursing staff to "disinfect" the multi-use glucometers after each use with an alcohol pad. Attendees included 10 facility Registered Nurses (RN) and/or Licensed Practical Nurses (LPN). Further review of the summary report revealed that the inservice did not include the use of EPA registered disinfecting wipes. On 05/28/21 at 8:16 AM, the Director of Nursing (DON) was asked to provide the facility policy for cleaning a glucose monitor and the actual hand booklet that came with the "Assure Platinum" blood glucose monitoring system. The DON verified that all glucometers in the building were "Assure Platinum" brand. Review of the "Assure Platinum" booklet revealed one procedure for cleaning and another procedure for disinfecting the glucometer. Further review of the manufacturer's booklet revealed to clean and disinfect the glucometer "cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. To use a	F 880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 39 wipe, remove from container and follow product label instructions to disinfect the meter . . . Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used; use one wipe to clean and a second wipe to disinfect . . . " Further review of the manufacturer's booklet revealed "to clean the outside of the blood glucose meter, use a lint-free cloth dampened with soapy water or isopropyl alcohol (70-80%). To disinfect the meter, dilute 1 mL of household bleach (5-6% sodium hypochlorite solution) in 9 mL of water to achieve a 1:10 dilution (final concentration of 0.5-0.6% sodium hypochlorite). The solution can then be used to dampen a paper towel (do not saturate the towel). Then use the dampened paper towel to thoroughly wipe down the meter. Please note that there are commercially available 1:10 bleach wipes from a variety of manufacturers. With all the recommended meter cleaning and disinfecting methods, it is critical the meter be completely dry before testing a resident's glucose level. Please follow the disinfectant product label instructions to ensure proper drying time." Review of the undated blood glucose monitoring policy provided by the facility and obtained from the "Corporate" policy book, revealed "clean and disinfect the blood glucose meter with a disinfectant pad, following the manufacturer's instructions. Contaminated blood glucose monitoring equipment increases the risk of infection by such bloodborne pathogens as hepatitis B, hepatitis C, and human immunodeficiency viruses." On 05/27/2021 at 7:48 A M, an observation was	F 880		

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F 880	Continued From page 40 conducted with LPN 3. LPN3 was observed wiping an "Assure" glucometer with a bleach wipe. LPN3 laid the glucometer on the surface of the medication cart without a barrier while gathering additional equipment. When asked, LPN3 did not know how long the glucometer was to stay wet from the bleach wipe to ensure proper disinfection. LPN3 proceeded to the isolation unit and placed the glucometer on top of the isolation supply cart. LPN3 did not place a barrier between the surface of the isolation supply cart and the "disinfected" glucometer. LPN3 donned (put on) personal protective equipment (PPE) in preparation to enter the isolation unit, picked up the glucometer, and entered the isolation area. At that time, LPN3 realized the resident, who was to have the fingerstick blood glucose test, was out to dialysis. LPN3 placed the glucometer on the surface of the medication cart located in the isolation unit without a barrier. LPN3 went into the hallway to doff (take off) her PPE and placed the glucometer on the surface of a cart in the hallway without a barrier. LPN3 picked up the glucometer and left the isolation unit and placed the glucometer, without placing down a barrier, on the surface of the medication cart used for residents not on isolation. LPN3 started to place the glucometer in the medication cart without disinfecting it after being on an isolation unit when the surveyor intervened. During an interview on 05/27/21 at 7:48 AM, LPN 3 stated that she should have used a barrier to place the glucometer on. When asked how long the glucometer was to remain wet from the bleach wipes to ensure disinfection, LPN3 did not know. During an interview on 05/27/21 at 7:55 AM, LPN2 was asked to demonstrate her procedure for fingerstick blood glucose testing using the	F 880		

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F 880	Continued From page 41 "Assure" glucometer. LPN2 sanitized her hands with an alcohol-based hand rub (ABHR) and wiped the glucometer with an alcohol pad. LPN2 then placed the glucometer on the surface of the medication cart without a barrier. LPN2 proceeded to demonstrate how she would obtain a blood sample from a resident and wipe the glucometer with an alcohol wipe. LPN2 then put the glucometer back in the medicine cart. LPN2 stated that her demonstration of how to "sanitize" the glucometer was according to facility policy. Observation on 05/28/21 at 4:32 PM, revealed Unit Manager 1 completing a blood glucose test. Unit Manager 1 wiped the glucometer off with an alcohol wipe, then gathered his supplies and entered a resident's room with the surveyor. Unit Manager 1 placed the glucometer on paper towels (a barrier) on the overbed table and went to the sink to wash his hands, put gloves on, and proceeded to wipe the resident's finger with an alcohol wipe. Unit Manager 1 pricked the resident's finger getting a blood sample and used the glucometer to obtain a blood sugar level. Unit Manager 1 put the glucometer in his pocket, left the resident's room, put the glucometer in a basket of clean needles and alcohol wipes located on the top of the medicine cart. Unit Manager 1 did not clean the glucometer before placing it in the basket. Observation on 5/28/21 at 5:07 PM, revealed Unit Manager completing a blood glucose test. Unit Manager 1 washed his hands and then wiped off the glucometer with an alcohol wipe, gathered his supplies, and entered another resident room with the surveyor. Unit Manager 1 placed the glucometer on the overbed table on paper towels used as a barrier and put on a pair of gloves. Unit	F 880		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 880	Continued From page 42 Manager 1 wiped the resident's finger with an alcohol wipe and pricked the resident's finger obtaining a blood sample. Unit Manager 1 used the glucometer to obtain a blood sugar level. After completing the fingerstick blood sugar test, Unit Manager 1 placed the dirty glucometer in the basket on the medicine cart containing clean supplies of needles and alcohol wipes. During an interview on 05/28/21 at 5:15 PM, Unit Manager 1 confirmed he always uses an alcohol pad to clean the glucometer.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883	F883 1) Residents #36,#27,#73 and #35 were offered the pneumococcal vaccine 2) An audit was completed by nursing management to identify any other residents that were not offered the pneumococcal vaccine. Residents identified were offered the vaccine 3) Admissions director and licensed staff were re-educated on the process for offering pneumococcal vaccine by the DON/designee. The DON/Designee will audit new admissions weekly x 1 month to ensure processes is being followed 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 883	Continued From page 43 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 883		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 883	Continued From page 44 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, interview, policy review, and review of Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer pneumococcal vaccines to four out of five residents (Resident (R) 36, R27, R73, and R35) reviewed for pneumococcal immunizations out of a sample of 20 residents. Failure to provide pneumococcal vaccines increased the risk for pneumococcal pneumonia, a type of bacterial pneumonia, that is a common cause of hospitalization and death in the elderly. Findings include: Review of CDC pneumococcal guidelines revealed "For adults 65 years or older who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant and want to receive PPSV23 ONLY: Administer 1 dose of PPSV23. Anyone who received any doses of PPSV23 before age 65 should receive 1 final dose of the vaccine at age 65 or older. Administer this last dose at least 5 years after the prior PPSV23 dose. For adults 65 years or older who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant and want to receive PCV13 AND PPSV23: Administer 1 dose of PCV13 first then give 1 dose of PPSV23 at least 1 year later. If the patient already received PPSV23, give the dose of PCV13 at least 1 year after they received the most recent dose of PPSV23. Anyone who received any doses of PPSV23 before age 65 should receive 1 final dose of the vaccine at age 65 or older. Administer this last dose at least 5 years after the prior PPSV23 dose.	F 883		

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	496149	A. BUILDING _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PORTSMOUTH HEALTH AND REHAB	900 LONDON BOULEVARD PORTSMOUTH, VA 23704

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F 883	Continued From page 45 Pneumococcal Vaccine Recommendations | CDC Review of the facility's policy titled, "Pneumococcal Vaccinations Policies and Procedures," effective date of 02/2017, indicated "all residents admitted to the facility will be given the opportunity to receive the pneumococcal vaccine per physician's order ...the vaccine should be documented on the MAR." During an interview on 05/28/21 at 11:50 AM, the Regional Clinical Director verified that the immunization records for R36, R27, R73, and R35 were not available. The Regional Clinical Director verified that medical records showed no documentation if R36, R27, R73, and R35 were offered, received, or declined the pneumococcal vaccine.	F 883		
F 919 SS=L	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a functioning call system that relayed a call to a staff member or to a centralized staff work area. The failure to have a functional call system resulted in immediate jeopardy for 70 of the 74 residents in the facility. Failure to have a functioning call	F 919	F919 1) The call light system has been repaired 2) Residents that resided in facility were at risk for this deficient practice. Residents have functioning call lights.. 3) Staff have been re-educated by Administrator/designee on reporting malfunctioning issues to Maintainence via TELS system. They have also been educated on the importance of monitoring resident call lights. The Maintainence director/Carekeepers will audit new panels and call light functioning 2x day 5x week x 2 months to ensure appropriate functioning of system 4) Results of audits will be reviewed in the monthly/Quarterly QAPI meeting. Any discrepancies will be addressed immediately and reeducation provided as needed 5) AOC date July 5th, 2021	

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F 919	Continued From page 46 system had the likelihood to result in harm or death as residents had no means to contact staff. On 05/24/21 at 6:46 PM, the Administrator and Director of Nursing (DON) were notified of an immediate jeopardy at F919-L Resident Call System. The immediate jeopardy began on 05/17/21 when the facility became aware that the call system was not functioning. The facility provided an acceptable plan for removal of the immediate jeopardy on 05/26/21 at 10:51 AM. The removal plan included providing a metal handheld bell to all residents cognitively and physically capable of using it, assigned staff members to continually monitor the halls for residents ringing the bells and to check on each resident at least every hour, and in-serviced all staff on the plan in place until the call system can be repaired. The survey team validated the immediate jeopardy was removed through observations, interviews, and review of inservice records. The deficiency remained at a lower scope and severity of an "F" following the removal of the immediate jeopardy. Findings include: On 05/24/21 at 11:14 AM, when asked about staff response to the call lights, resident (R) 42 stated the staff do not answer the call light because the call light was not working. R42 stated that when the button is pushed the light comes on but the light goes out when the button is no longer being pushed. The call light was checked by the surveyor and when pushed the light did not activate. R42's roommate's light was also checked and did not function. R42 stated the call light had not functioned in a long time.	F 919		

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F 919	Continued From page 47 Review of R42's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/01/21 revealed R42 had a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 indicating he was cognitively intact. Further review of this MDS revealed R42 required supervision with bed mobility, transfers, walking, dressing, eating, toilet use, and personal hygiene. On 05/24/21 at 11:36 AM, call lights in resident rooms 1 through 43 and rooms 53 through 72 were tested with the assistance of the Director of Nursing (DON). On 05/24/21 at 12:15 PM, the call lights in rooms 44, 45, 46, 47, 48, 49, 50, and 51 were tested with the assistance of the Maintenance Supervisor (MS). The call lights did not function in 53 of 55 occupied resident rooms and had the potential to affect 70 of the facilities 74 residents. At the time the lights were tested on 05/24/21, both the DON and MS verified the lights were not functioning. On 05/24/21 at 11:39 AM, R8 stated "sometimes the call light works and sometimes it does not." R8 stated most of the time it did not work and when it did work it was so dimly lit over the door the staff could not tell it was on. On 05/24/21 at 11:39 AM, when tested by the surveyor, R8's call light would go on while the button was actively being pushed and then would immediately go off when it was not being pushed. The light over the door in the hall was very dim and it was hard to tell it was on. Review of R8's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/18/21 revealed R8 had a "Brief Interview for Mental Status (BIMS)" score of 15	F 919		

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F 919	Continued From page 48 out of 15 indicating she was cognitively intact. Further review of this MDS revealed R8 required extensive assistance for bed mobility, dressing, toilet use, and hygiene. R8 was dependent on a wheelchair for locomotion. On 05/24/21 at 11:53 AM, when the door to R54's room was opened to check his call light, R54 stated he had been ringing a handheld bell for an hour, and no one had come because someone closed the door, and no one could hear the bell. R54 was in bed and wanted to get up in his chair. R54 stated the staff had given him the bell that day although the call light had not worked for six weeks. Review of R54's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/14/21 revealed a "Brief Interview for Mental Status (BIMS)" of 13 indicating he was cognitively intact. R54 required extensive assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. R54 was dependent on a wheelchair for locomotion. R54's diagnoses on this MDS included paraplegia and pressure ulcers. While going from room to room checking the call lights on 05/24/21, the DON stated the facility had given some residents bells a couple of weeks ago because they found some rooms where the lights did not function. The DON stated she knew some of the lights did not function but did not know it was so widespread. On 05/24/21 at 10:42 AM, R48 stated his call light did not work. R48 stated that he must wait until someone comes in before he gets help. R48 did not have a handheld bell in his room. The call	F 919		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 919	Continued From page 49 light for both beds in the room were tested at that time and neither one functioned. Review of R48's quarterly "Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/02/21 revealed a "Brief Interview for Mental Status (BIMS)" of 15 out of 15 indicating he was cognitively intact. Further review of this MDS revealed R48 required supervision with dressing, eating, toilet use, and personal hygiene. R48 was not steady with transfers and walking and required the use of a walker for ambulation. On 05/24/21 at 11:14 AM, R4 stated his call light did not work and he was given a handheld bell to ring. R4 stated when he rings the bell "no one ever answers it." Review of R4's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/12/21 revealed a "Brief Interview for Mental Status (BIMS)" of 15 out of 15 indicating he was cognitively intact. Further review of this MDS revealed R4 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene; limited assistance with transfers; he was not steady with transfers and required a wheelchair for mobility. On 05/24/21 at 11:30 AM, R60's call light was checked and did not function. R60 had a bell in her room and when she was asked about the bell, she stated she did not know why she had it. Review of R60's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/16/21 revealed a "Brief Interview for Mental Status (BIMS)" of 9, indicating moderately impaired cognition. Further review of this MDS	F 919		

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F 919	Continued From page 50 revealed R60 required extensive assistance with bed mobility, transfers, dressing, eating, toilet use and personal hygiene. R60 was not steady with standing and transfers and utilized a wheelchair for mobility. During an interview on 05/24/21 at 11:26 AM, when R34 was asked where her call light /bell was, she stated it "does not matter they do not come." When asked who is they? Resident indicated "the people to help me [staff] they do not come." There was no bell observed in the R34's room and the call light did not work. Review of R34's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/16/21 revealed a "Brief Interview for Mental Status (BIMS)" of 99 indicating she was not cognitively intact. Further review of this MDS revealed R34 required supervision for bed mobility, transfers, dressing, toilet use and personal hygiene; she was not steady during transfers and walking; and she used a walker as a mobility device. Staff interviews regarding staff awareness of how long the call lights were not functioning revealed the following: On 05/24/21 at 2:09 PM, Licensed Practical Nurse (LPN) 1 stated she was aware the light had not been functioning and when ask what she does about it she stated she gives them another call cord or a handheld bell. On 05/24/21 at 2:12 PM, Certified Nursing Assistant (CNA) 2 stated she knows the call lights were not working and she stated she checks on the residents continuously.	F 919		

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F 919	Continued From page 51 On 05/24/21 at 2:13 PM, LPN 2 stated she knew certain call lights do not work and she makes rounds to check on her residents and they now have bells. On 05/24/21 at 2:17 PM, CNA 1 stated that the call light system has not worked for at least eight weeks. On 05/24/21 at 3:38 PM, the Administrator stated that on 05/17/21 staff completed a 100% check of the call system and identified seven (7) rooms with non-functioning call lights. The Administrator stated two of the residents were relocated and the other residents in the affected rooms were provided with a handheld bell. The Administrator stated that since identifying the nonfunctioning call lights on 05/17/21, no monitoring of the call system had been in place and administration was relying on staff to tell them if the call lights were not functioning properly.	F 919		