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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 11/29/2021 through 12/02/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/29/2021 through 12/02/2021. Nine complaints (VA00050023-substantiated with deficiencies, VA00053506 - unsubstantiated, VA00052476 - substantiated with deficiencies, VA00053338 - unsubstantiated, VA00051138 - unsubstantiated, VA00050967 - unsubstantiated, VA00050063 - substantiated with no deficiencies, VA00050795 - substantiated with no deficiencies, VA00053738 - unsubstantiated), were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 94 at the time of the survey. The survey sample consisted of 37 current resident reviews and nine closed record reviews.	F 000	To remain in compliance with federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. alleged deficiencies cited have been or are to be corrected by the date or dates indicated.	
F 565	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.	F 565	**F565** 1. The residents were identified, inventory sheets reviewed, searches done for missing items and replacements for items purchased.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Doris Mosley, LNHA | TITLE: Interim Executive Director/Administrator | (X6) DATE: 12.22.21

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 565	Continued From page 1 (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to respond to a grievance expressed during a resident council meeting for one of three resident council meetings reviewed. The facility staff failed to ensure a concern expressed regarding laundry during the August 2021 resident council meeting was responded to and addressed.	F 565	2. An audit of last six months of resident council concerns revealed no other issues. The laundry process for the center was reviewed and modified. 3. The Administrator will re-educate staff on the grievance process to include missing items process. 4. Resident council minutes will be reviewed monthly by the Administrator to ensure any grievance expressed was addressed. Results will be presented to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately. 5 Compliance Date: 01/04/22	

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F 565	Continued From page 2	F 565		

The findings include:

A review of Resident Council Minutes from August 2021 revealed the following entry: "Residents complained that laundry isn't coming back and or they are getting the wrong clothing items."

On 12/1/21 at 4:50 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical operations, and ASM #5, the regional vice president of operations, were informed of these concerns. Evidence that the concern regarding laundry had been addressed and resolved was requested.

On 12/2/21 at 8:56 a.m., ASM #1 presented a facility concern form. This form stated: "7/13/21 Resident Council...Documentation of Concern: 10 residents complained that laundry isn't coming back and they are getting the wrong clothes back...Documentation of Facility Follow-Up (blank lines)...Resolution of Concern (blank lines)." ASM #1 stated: "We had this documented as a concern on a concern form, but I can't find that it was followed up."

On 12/2/21 at 9:07 a.m., OSM (other staff member) #10, the social services assistant, was interviewed. She stated she has only been in her position for five days. She stated her understanding of the resident council process is that when a concern is expressed by the resident, the concern is documented on a formal concern form. The form is given to the staff person responsible for the area of concern. The staff member addresses the concern and documents

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F 565	Continued From page 3 their actions. The form then goes to the administrator, who discusses the outcome with leadership staff at the daily morning meeting. After this discussion, OSM #10 is responsible for logging the concern in the concern log she keeps. The staff member responsible for attending the August 2021 resident council meeting and distributing the concerns was not available for interview during the time of the survey. A review of the facility policy, "Concerns," revealed, in part: "Upon identification of a patient or representative concern, staff completes the Concern Form identifying the issue and forward the form to the Administrator or designee...The Administrator...copies and forwards the Concern Form to the appropriate department head for follow-up and resolution during the morning meeting...The assigned department head investigates the identified concern timely and interviews staff and patients as appropriate to identify root cause of the issue or concern. Once the root cause of the concern is identified, corrective action is taken to resolve the issue for the identified party as well as potential systemic changes to reduce risk of recurrence or occurrence for others. The assigned department head contacts the appropriate party once resolution has been completed. Once resolved, the concern form is updated with the resolution of the concern and returned to the Administrator." No further information was provided prior to exit.	F 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580	**F580** 1. Resident #201 discharged from the center on 05/24/21.	

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F 580	Continued From page 4 (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15)	F 580	2. No other residents had the potential to be affected as there was no other resident admitted on 5/22/21. New admissions in the last 30 days medications reviewed to ensure physician notification if medication was unavailable. 3. The DON/designee will re-educate licensed nurses within the center of the requirement to notify the physician for medications that are not available. 4. A report will be generated of medications not given 5 times a week, report will be reviewed for notification of physician. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately. 5. Compliance Date 01/04/22	

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Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility document review and staff interview it was determined that the facility staff failed to notify the physician that a resident's medications were not available for administration for one of 46 residents in the survey sample, Resident # 201.

The facility staff failed to notify Resident # 201's physician that the medications, metoprolol, zestoretic, gabapentin, glimepiride, and ozempic, were not available for administration on 05/22/2021 and 05/23/2021.

The findings include:

Resident # 210 was admitted to the facility with diagnoses that included but were not limited to: breast cancer, pain, diabetes mellitus [6] and kidney disease, high blood pressure.

Resident # 201's MDS (minimum data set), an admission 5-day assessment with an ARD (assessment reference date) of 05/24/2021 coded Resident # 201 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

Review of Resident #201's clinical record

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revealed a physician's order dated 5/21/21, signed by the physician on 5/24/21, which documented in part: "Metoprolol [1] ER [extended release] 25mg [milligrams]. Give 1 [one] tablet by mouth one time a day for htn [hypertension - high blood pressure]; Zestoretic [2] 20-25 mg. Give 1 [one] tablet by mouth one time a day for htn [hypertension - high blood pressure]; Gabapentin [3] Capsule. Give 300 mg by mouth two times a day for neuropathy; Glimepiride [4] Tablet. Give 2mg by mouth two times a day for DM [diabetes mellitus]; Ozempic [5] (0.25 or 0.5 MG/DOSE) Solution Pen-Injector 2 MG/1.5ML [milliliter]. Inject 0.5 mg subcutaneously [beneath the skin] one time a day every Sun [Sunday] for dm."

Review of the eMAR [electronic medication administration record] dated May 2021 for Resident # 201 documented the physician's orders as stated above from 05/21/2021 through 05/24/2021. The eMAR further documented the code "3 [three] = Hold/See Nurse's Notes" for metoprolol on 5/22/2021 and 05/23/2021 at 9:00 a.m.; ozempic on 05/23/2021 at 9:00 a.m.; zestoretic on 05/22/2021 and 05/23/2021 at 9:00 a.m.; gabapentin on 05/22/2021 at 9:00 a.m.; glimepiride 5/22/2021 and 05/23/2021 at 9:00 a.m. and coded "7 [seven] = See Nurse's Notes" on 05/24/2021 at 9:00 a.m.

The nurse's "Progress Notes" dated 05/22/2021 and 05/23/2021 for Resident # 201 documented, "Gabapentin Capsule. Give 300 mg by mouth two times a day for neuropathy. Pharm [pharmacy] sent wrong dose; Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG. Give 1 tablet by mouth one time a day for htn. awaiting delivery; Glimepiride Tablet. Give 2 mg by mouth two times a day for DM. awaiting

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delivery."

The nurse's "Progress Notes" dated 05/23/2021 "Ozempic (0.25 or 0.5 MG/DOSE) Solution Pen-injector 2 MG/1.5ML. Inject 0.5 mg subcutaneously one time a day every Sun [Sunday] for dm. awaiting delivery."

Further review of Resident # 201's clinical record failed to reveal that the physician was notified that the above medications were not available or administered.

On 12/01/2021 at 8:18 a.m., a request to interview the nurse who admitted resident # 201 was made to ASM [administrative staff member] # 1, interim administrator. ASM # 1 stated that the nurse was no longer employed by the facility.

On 12/01/2021 at approximately 10:05 a.m., an interview was conducted with ASM # 2, director of nursing. When asked to describe the procedure to obtain medications for newly admitted residents that is followed by nursing, ASM # 2 stated, "Before they arrive, we get a report from the hospital or they arrive with a discharge summary with their medications. The admitting nurse calls the nurse practitioner [NP] or the physician to go over the resident's medications and make any necessary changes and then they give a verbal order for the medications. The order is then faxed to the pharmacy If there is a narcotic, the nurse gets a written order. If the resident is a late day admission the medications arrive the next morning, if the admission is early in the day, the medications arrive by the end of the day." When asked about the procedure staff follow when a resident's medication are not available, ASM # 2 stated, "They [nurse] checks

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the STAT [immediate]-drug box [prepared by the pharmacy to provide for initiating therapy prior to the receipt of ordered drug from the pharmacy] and the house stock of medications. If they [medications] are not in the STAT-drug box or in the house stock, the nurse should call the pharmacy, notify the NP or physician, and let the resident and/or responsible party know." When asked where it was documented that a medication was not available and that the pharmacy and NP/physician were notified, ASM # 2 stated, "On the eMAR and or the nurse's progress notes." After reviewing Resident # 201's eMAR dated May 2021, nurse's progress notes dated 05/21/2021 through 05/24/2021, the STAT-drug box list and the facility's house stock list, ASM # 2 was asked if the pharmacy, NP/ Physician was notified of Resident # 201's medications listed above were not available and administered. ASM # 2 stated no.

The facility policies regarding medication administration failed to document specific information regarding physician notification for medications not available for administration.

On 12/01/2021 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the interim administrator, ASM # 2, director of nursing, ASM # 4, director of clinical operations and ASM # 5, regional vice president of operations, were made aware of the findings.

No further information was provided prior to exit.

Complaint deficiency

References:

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[1] Used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html.

[2] The combination of lisinopril and hydrochlorothiazide is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601070.html.

[3] Used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html.

[4] Used along with diet and exercise, and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a696016.html.

[5] Used along with a diet and exercise program to control blood sugar levels in adults with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) when other medications did not control the sugar levels well

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F 580	Continued From page 10 enough. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a618008.html. [6] A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review it was determined that the facility staff failed to ensure one of 46 residents in the survey sample, (Resident #96), was free from abuse. On 7/9/20, at 10:30 p.m. a facility CNA [certified nursing assistant] attempted to give Resident #96	F 600	**F600** 1. Resident #96 remains safe and secure in the center with no post trauma effects noted. 2. Current residents in the center have the potential to be affected. Randomly selected residents that are alert and oriented were interviewed to determine any potential issues. No concerns identified. 3. The Administrator/designee will re-educate staff on the Abuse and Neglect policy.	

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F 600	Continued From page 11	F 600	4. Random knowledge checks will be completed with associates in different departments weekly for 1 month to ensure residents are free from abuse. Results will be presented to QAPI monthly. Any noted trends will be addressed immediately. 5) Compliance Date: 01/04/22	

a bath and the resident declined stating they were tired. The CNA proceeded with the bath, upsetting the resident. Resident #96 cursed at the CNA and the CNA subsequently cursed at Resident #96 and was rude to the resident.

The findings include:

Resident #96 was admitted to the facility on 1/6/18 with diagnosis that included but were not limited to: CVA 'cerebrovascular accident' (hemorrhage of blockage of the blood vessels of the brain leads to lack of oxygen to brain) (1), hemiplegia (paralysis only affecting one side of the body) (2) and vascular dementia (progressive state of mental decline, including memory function and judgement due to impairment of vasculature of the brain) (3).

The most recent MDS (minimum data set) assessment, a quarterly and 5 day assessment, with an ARD (assessment reference date) of 11/15/21, coded Resident #96 as scoring a 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded Resident #96 as requiring extensive assistance for bed mobility, transfer, locomotion, dressing, hygiene; dependent for bathing and supervision for eating. Walking did not occur. A review of MDS Section H- Bowel and Bladder coded Resident #96 as always incontinent for bowel and for bladder.

A review of the comprehensive care plan dated 1/6/18 documented in part, "FOCUS: I have a physical functioning deficit related to: Mobility impairment, Self-care impairment, history of CVA with resulting hemiplegia. INTERVENTIONS:

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Encourage choices with care."

A review of the FRI dated 7/10/20, documented in part, "CNA (certified nursing assistant) giving resident a bed bath at 10:30 PM. Resident stating he did not want bed bath at that time, as he was tired. Resident said he wanted to wait until tomorrow. CNA proceeded with bed bath and resident was upset. He began cursing at CNA. CNA allegedly cursed back at resident and was rude with him. After review of the incident to include statements and interview with Resident #96, it has been determined that this allegation has been substantiated due to poor customer service, verbal abuse and mistreatment of the resident, it has been determined that the employee will no longer be used as a traveler CNA in the facility."

A review of the nursing progress note dated 7/10/20 at 1:44 PM, documented in part, "Alleged verbal altercation between resident and CNA (certified nursing assistant) during bed bath. Notification of NP (nurse practitioner), POA (power of attorney), DON (director of nursing), Administrator, and Berryville Police Department. All paperwork completed."

A review of the nursing progress note dated 7/10/20 at 2:36 PM, documented in part, "Resident alert. Makes needs/wants known. No complaints voiced. No apparent complications or complaint post alleged verbal altercation. Temperature-97.2, Pules-65, Respirations-16, Blood pressure-103/69, oxygen saturation- 97% on room air."

A review of the nursing progress note dated 7/10/20 at 2:38 PM, documented in part, "Spoke

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with resident in regards to alleged verbal altercation with CNA. Resident exhibits no signs of any emotion distress and states he is fine. Psych [psychiatry] to follow as needed."

A review of the nursing progress note dated 7/11/20 at 12:04 AM, documented in part, "Status post verbal altercation. resident is amicable and works well with staff. resident shows no signs of behaviors."

A review of the nursing progress note dated 7/13/20 at 7:39 AM, documented in part, "Resident continues to show no signs of any emotional distress due to alleged verbal altercation with CNA.

An interview was conducted on 11/29/21 at 5:15 PM with Resident #96. When asked if he remembered the incident with the nursing assistant, Resident #96 stated, "You mean when he gave be a bed bath and I didn't want one." Resident #96 stated, "Yes, it was late in the evening and I wanted to go to sleep. He argued with me and said bad things to me. I don't think he works here anymore."

An interview was conducted on 11/29/21 at 5:35 PM with LPN (licensed practical nurse) #3. When asked if she remembered an incident with Resident #96 in July 2020, LPN #3 stated, "No, I do not." When asked what abuse was, LPN #3 stated, "It can be verbal, physical, mental or neglect. It can be resident to resident or staff to resident. If we hear or see abuse, we report it immediately."

An interview was conducted on 11/30/21 at 2:37 PM with LPN #2, unit manager north wing. When

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asked if she remembered the incident with Resident #96 and a CNA, July 2020, LPN #2 stated, "Yes, the resident did not want a bath at that time and the CNA proceeded to do the bath even though the resident said he did not want the bath at that time, which was late evening, about 10:30 PM. We suspended the CNA, who was a traveler, pending the investigation and then terminated him. I believe we did substantiate verbal abuse."

A request was made for the final FRI including the investigation on 11/30/21 at 8:15 AM. The final FRI with investigation was provided by the ASM (administrative staff member) #1 on 12/1/21 at 1:10 PM. When asked about the FRI, ASM #1 stated, "It was not with the rest of the FRI's. It was in a separate folder. This happened before I was hired here. I've been here 7 days."

On 12/1/21 at 5:00 PM, ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were informed of the findings.

A review of the facility's "Abuse and Neglect" policy dated 4/2020, which documents in part, "It is inherent in the nature and dignity of each resident at the facility that he/she be afforded basic human rights, including the right to be free from abuse, neglect and mistreatment and/or misappropriation of property. Acts of abuse directed at residents are strictly prohibited. Verbal abuse means the use of oral, written or gestured language that willfully includes disparaging and/or derogatory terms to residents or their families, within their hearing distance, regardless of their

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F 600	Continued From page 15 age, ability to comprehend or disability."\ No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 264. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement the facility abuse policy for one of 46 residents in the survey sample, Resident #7. The facility staff failed to implement the facility	F 607	**F607** 1. Resident #7 remains safely in the community. No current skin related issues noted. 2. Current residents in the center have the potential to be affected. Skin sweeps of current residents in the center were completed on 12/8/2021. No new issues noted. 3. The Administrator will re-educate clinical leadership on the policy of investigating bruises on unknown origin.	

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F 607	Continued From page 16	F 607	4. Incidents/accidents that involve bruising will be audited weekly for 1 month to ensure that abuse policy was implemented. Results will be presented to QAPI monthly. Any noted trends will be addressed immediately. 5. Compliance Date: 01/04/22	

abuse policy for investigating and reporting an injury of unknown origin when Resident #7 sustained a bruise on 8/5/21.

The findings include:

The facility policy titled, "Resident Abuse- Injuries of Unknown Origin" documented, "4. The Administrator, Director of Nursing, or their designee, must begin a documented investigation for the cause of the injury. 5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements as deemed necessary. 7. All injuries of unknown origin must be reported to the appropriate agencies per state specific protocols..."

Resident #7 was admitted to the facility on 7/15/19. Resident #7's diagnoses included but were not limited to diabetes, paralysis and dementia. Resident #7's five day Medicare minimum data set assessment with an assessment reference date of 11/11/21, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #7 as requiring extensive assistance of two or more staff with bed mobility.

Review of Resident #7's clinical record revealed a nurse's note dated 8/5/21 and signed by LPN (licensed practical nurse) #1 that documented, "Situation: Resident observed with a dark purple bruise that is starting to have faded green on her R. (right) upper arm from elbow to the shoulder. Front and posterior (back) shoulder and axilla (armpit). Resident alert with some confusion

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episodes. Does not voice her concerns very well. No s/s (signs or symptoms) distress or discomfort. Resting in her room at this time with call bell in reach
Background: CVA (cerebrovascular accident [stroke]), falls,
Assessment: Head to toe
Response: MD (medical doctor) and RP (responsible party) aware. Will continue to monitor."

A bruise investigation dated 8/5/21 documented, "Describe the bruise: Dark purple and some green faded. Location: R arm, shoulder, axilla. Size: whole upper arm & shoulder (front) (posterior). Color: Dark purple and some green faded. Caregiver/Employee reporting: (name of LPN #1). Date reported: 8/5/21. Time reported: 1100 AM. Resident cognition: alert w/ (with) confusion. Does the resident ambulate alone- No. Does the resident wheel themselves around in a W/C (wheelchair) - No...Administrator Notified- Yes. Director of Nursing Notified- Yes...Based on investigation, determination of the cause of the bruise: (blank). DON (Director of nursing) or designee to complete interviews of staff and document responses. Caregiver/Employee's Name: (LPN #1). Date: 8/5/21. Shift: 7-3. Response: I have been off for a month when I removed her sheet I observed the bruise." Supervisor Report. (An "X" beside) In my professional opinion, no abuse, neglect or mistreatment occurred. Further investigation Required- (blank). Details of investigation and resolution: (blank). Signature of DON: (blank). Date: (blank)."

Review of the above investigation and nurses' notes for August 2021 failed to reveal a complete

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and thorough investigation. Also, a FRI (facility reported investigation) was not submitted to the SA (state agency) or any other agency.

On 12/1/21 at 8:04 a.m., an interview was conducted with LPN #1. LPN #1 stated she had been off of work for a month and returned on 8/5/21. LPN #1 stated that on 8/5/21 she noticed Resident #7 had purplish but greenish and yellowing bruising from her right shoulder to her right elbow. LPN #1 stated it looked like the bruising was fading. LPN #1 stated she completed the above nurse's note, completed an incident report and gave the report to the DON. LPN #1 stated the DON is responsible for investigating bruises.

On 12/1/21 at 1:48 p.m., an interview was conducted with ASM (administrative staff member) #3 (the DON). ASM #3 was not the DON on 8/5/21. ASM #3 stated the DON is responsible for investigating resident bruises. ASM #3 stated the investigation should consist of a complete head to toe assessment, speaking with the resident if he/she is alert and oriented, speaking to staff possibly the staff on the last several shifts, depending on the looks of the bruise, and possibly speaking with the resident's roommate. ASM #3 stated if the cause of the bruise is unknown then the bruise should be reported as an injury of unknown origin to the state agency and other required agencies. ASM #3 was shown the above bruise investigation form. ASM #3 stated she thought she remembered the former DON and LPN #1 talking about Resident #7's bruise. ASM #3 stated she thought the former DON thought the bruise was from a mechanical lift and that could be why the former DON did not submit a FRI. ASM #3 stated

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this is the information she heard but by looking at the bruise investigation form, she did see where it looked like an investigation was completed.

On 12/1/21 at 4:56 p.m., ASM (administrative staff member) #1 (the interim administrator), ASM #2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 (the regional vice president of operations) were made aware of the above concern.

No further information was presented prior to exit.

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

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her

F 607

F 609 **F609**

1. Resident #7 remains safely in the community. No current skin related issues noted

2. Residents in the center that have sustained a bruise within the last 30 days have the potential to be affected. These residents were reviewed and no issues with notification noted.

3. Re-education of the resident abuse-injuries of unknown origin policy was completed by current center leadership and appropriate licensed staff.

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F 609	Continued From page 20	F 609	4. Incidents/accidents will be audited weekly for 1 month to ensure they were reported if appropriate. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date 01/04/22	

designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to report an injury of unknown origin for one of 46 residents in the survey sample, Resident #7.

Resident #7 sustained a bruise of unknown origin on the right arm extending from the shoulder to elbow that was found on 8/5/21. The facility staff failed to report this injury of unknown origin to the SA (state agency) and other required agencies.

The findings include:

Resident #7 was admitted to the facility on 7/15/19. Resident #7's diagnoses included but were not limited to diabetes, paralysis and dementia. Resident #7's five day Medicare minimum data set assessment with an assessment reference date of 11/11/21, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #7 as requiring extensive assistance of two or more staff with bed mobility.

Review of Resident #7's clinical record revealed a nurse's note dated 8/5/21 and signed by LPN (licensed practical nurse) #1 that documented, "Situation: Resident observed with a dark purple bruise that is starting to have faded green on her R. (right) upper arm from elbow to the shoulder. Front and posterior (back) shoulder and axilla

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(armpit). Resident alert with some confusion episodes. Does not voice her concerns very well. No s/s (signs or symptoms) distress or discomfort. Resting in her room at this time with call bell in reach
Background: CVA (cerebrovascular accident [stroke]), falls,
Assessment: Head to toe
Response: MD (medical doctor) and RP (responsible party) aware. Will continue to monitor."

A bruise investigation dated 8/5/21 documented, "Describe the bruise: Dark purple and some green faded. Location: R arm, shoulder, axilla. Size: whole upper arm & shoulder (front) (posterior). Color: Dark purple and some green faded. Caregiver/Employee reporting: (name of LPN #1). Date reported: 8/5/21. Time reported: 1100 AM. Resident cognition: alert w/ (with) confusion. Does the resident ambulate alone- No. Does the resident wheel themselves around in a W/C (wheelchair) - No...Administrator Notified- Yes. Director of Nursing Notified- Yes...Based on investigation, determination of the cause of the bruise: (blank). DON (Director of nursing) or designee to complete interviews of staff and document responses.
Caregiver/Employee's Name: (LPN #1). Date: 8/5/21. Shift: 7-3. Response: I have been off for a month when I removed her sheet I observed the bruise." Supervisor Report. (An "X" beside) In my professional opinion, no abuse, neglect or mistreatment occurred. Further Investigation Required- (blank). Details of investigation and resolution: (blank). Signature of DON: (blank). Date: (blank)." The investigation failed to document a potential cause for the bruise.

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A FRI (facility reported investigation) regarding Resident #7's bruise of unknown origin was not submitted to the SA (state agency) or any other required agency.

On 12/1/21 at 8:04 a.m., an interview was conducted with LPN #1. LPN #1 stated she had been off of work for a month and returned on 8/5/21. LPN #1 stated that on 8/5/21 she noticed Resident #7 had purplish but greenish and yellowing bruising from her right shoulder to her right elbow. LPN #1 stated it looked like the bruising was fading. LPN #1 stated she completed the above nurse's note, completed an incident report and gave the report to the DON.

On 12/1/21 at 1:48 p.m., an interview was conducted with ASM (administrative staff member) #3 (the DON). ASM #3 was not the DON on 8/5/21. ASM #3 stated the DON is responsible for investigating resident bruises. ASM #3 stated if the cause of the bruise is unknown then the bruise should be reported as an injury of unknown origin to the state agency and other required agencies. ASM #3 was shown the above bruise investigation form. ASM #3 stated she thought she remembered the former DON and LPN #1 talking about Resident #7's bruise. ASM #3 stated she thought the former DON thought the bruise was from a mechanical lift and that could be why the former DON did not submit a FRI. However, there was no documented cause of the bruise.

On 12/1/21 at 4:56 p.m., ASM (administrative staff member) #1 (the interim administrator), ASM #2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 (the regional vice president of operations) were made

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F 609	Continued From page 23 aware of the above concern. The facility policy titled, "Resident Abuse- Injuries of Unknown Origin" documented, "7. All injuries of unknown origin must be reported to the appropriate agencies per state specific protocols..." No further information was presented prior to exit.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to investigate an injury of unknown origin for one of 46 residents in the survey sample, Resident #7.	F 610	**F610** 1. Resident #7 remains safely in the community. No current skin related issues noted 2. Residents in the center that have sustained a bruise within the last 30 days have the potential to be affected. These residents were reviewed and no issues with investigation noted. 3. Re-education of the investigation requirements was completed by center leadership and appropriate licensed staff. 4. Incidents/accidents will be audited weekly for 1 month to ensure they were investigated if	

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Resident #7 sustained a bruise of unknown origin on the right arm extending from the shoulder to elbow on 8/5/21. The facility staff failed to complete a thorough investigation to determine the cause of the bruise.

The findings include:

Resident #7 was admitted to the facility on 7/15/19. Resident #7's diagnoses included but were not limited to diabetes, paralysis and dementia. Resident #7's five day Medicare minimum data set assessment with an assessment reference date of 11/11/21, coded the resident's cognitive skills for daily decision making as severely impaired. Section G coded Resident #7 as requiring extensive assistance of two or more staff with bed mobility.

Review of Resident #7's clinical record revealed a nurse's note dated 8/5/21 and signed by LPN (licensed practical nurse) #1 that documented, "Situation: Resident observed with a dark purple bruise that is starting to have faded green on her R. (right) upper arm from elbow to the shoulder. Front and posterior (back) shoulder and axilla (armpit). Resident alert with some confusion episodes. Does not voice her concerns very well. No s/s (signs or symptoms) distress or discomfort. Resting in her room at this time with call bell in reach
Background: CVA (cerebrovascular accident [stroke]), falls,
Assessment: Head to toe
Response: MD (medical doctor) and RP (responsible party) aware. Will continue to monitor."

A bruise investigation dated 8/5/21 documented,

appropriate. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.

5. Compliance Date 01/04/22

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"Describe the bruise: Dark purple and some green faded. Location: R arm, shoulder, axilla. Size: whole upper arm & shoulder (front) (posterior). Color: Dark purple and some green faded. Caregiver/Employee reporting: (name of LPN #1). Date reported: 8/5/21. Time reported: 1100 AM. Resident cognition: alert w/ (with) confusion. Does the resident ambulate alone- No. Does the resident wheel themselves around in a W/C (wheelchair) - No...Administrator Notified- Yes. Director of Nursing Notified- Yes...Based on investigation, determination of the cause of the bruise: (blank). DON (Director of nursing) or designee to complete interviews of staff and document responses. Caregiver/Employee's Name: (LPN #1). Date: 8/5/21. Shift: 7-3. Response: I have been off for a month when I removed her sheet I observed the bruise." Supervisor Report. (An "X" beside) In my professional opinion, no abuse, neglect or mistreatment occurred. Further Investigation Required- (blank). Details of investigation and resolution: (blank). Signature of DON: (blank). Date: (blank)."

Review of the above investigation and nurses' notes for August 2021 failed to reveal a complete and thorough investigation.

On 12/1/21 at 8:04 a.m., an interview was conducted with LPN #1. LPN #1 stated she had been off of work for a month and returned on 8/5/21. LPN #1 stated that on 8/5/21 she noticed Resident #7 had purplish but greenish and yellowing bruising from her right shoulder to her right elbow. LPN #1 stated it looked like the bruising was fading. LPN #1 stated she completed the above nurse's note, completed an incident report and gave the report to the DON.

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LPN #1 stated the DON is responsible for investigating bruises.

On 12/1/21 at 1:48 p.m., an interview was conducted with ASM (administrative staff member) #3 (the DON). ASM #3 was not the DON on 8/5/21. ASM #3 stated the DON is responsible for investigating resident bruises. ASM #3 stated the investigation should consist of a complete head to toe assessment, speaking with the resident if he/she is alert and oriented, speaking to staff (possibly the staff on the last several shifts, depending on the looks of the bruise), and possibly speaking with the resident's roommate. ASM #3 was shown the above bruise investigation form. ASM #3 stated she thought she remembered the former DON and LPN #1 talking about Resident #7's bruise. ASM #3 stated she thought the former DON thought the bruise was from a mechanical lift. ASM #3 stated this is the information she heard but by looking at the bruise investigation form, she did see where it looked like an investigation was completed.

On 12/1/21 at 4:56 p.m., ASM (administrative staff member) #1 (the interim administrator), ASM #2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 (the regional vice president of operations) were made aware of the above concern.

The facility policy titled, "Resident Abuse- Injuries of Unknown Origin" documented, "4. The Administrator, Director of Nursing, or their designee, must begin a documented investigation for the cause of the injury. 5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors or volunteers which may have had contact with

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F 610	Continued From page 27 the resident and may help with the investigation. Obtain written statements as deemed necessary..." No further information was presented prior to exit.	F 610		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate.	F 622	**F622** 1. Resident #91 is no longer in the center. Residents #29, #13, #49, and #26 remain safely in the community and have not had any transfers within the last 30 days. 2. Residents in the center that have been transferred within the last 30 days have the potential to be affected. These residents were reviewed and no issues with notification noted. 3. The DON/designee provided re-education of the documentation requirement to licensed providers of the center and provided an in-service on the center's Transfer to the Hospital policy to licensed nurses in the center.	

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F 622	Continued From page 28	F 622	4. Transfers will be audited weekly for 1 month to ensure there is corresponding physician note and that the appropriate paperwork was provided to the receiving facility. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date 01/04/22	

(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider

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must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence physician documentation of the rationale for and/or failed to provide all required documentation to the receiving facility for transfer to the hospital for five of 46 residents in the survey sample; Residents #91, #49, #26, #29 and #13.

1. The facility staff failed to evidence the physician wrote a note regarding the reason for Resident #91's hospital transfer on 10/26/21, and that all required documentation was provided to the receiving facility.

2. The facility staff failed to evidence the physician wrote a note regarding the reason for Resident #49's hospital transfer on 8/19/21 and 9/1/21, and that all required documentation was provided to the receiving facility for both transfers.

3. The facility staff failed to evidence that all

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required documentation was provided to the receiving facility when Resident #26 was transferred to the hospital on 9/15/21 and 11/4/21.

The findings include:

A review of the facility policy, "Transfer a Resident to a Hospital" documented:
Emergency Transfer
1. Call the physician and obtain an order to transfer the resident.
2. Call the ambulance.
3. Complete the Interact Facility Transfer Form.
4. Print two copies of the residents chart via (electronic health record system). A. one copy for EMS and one for the hospital.
5. Place printed content into 2 transfer envelopes.
6. Notify the family or responsible party of the pending transfer, and the reasons for the move.
7. Obtain information necessary for telephone report. A. Vital signs. B. Medical history - Include allergies. C. Resident's status: i. Reason for admission. ii. Problems and goals identified and treatment plan. iii. Reason for transfer. D. Name and number of significant other. E. DNR [do not resuscitate] status. F. Precautions (respiratory/contact).
8. Identify equipment and belongings sent with resident on Inventory of Personal Effects.
9. Send a copy of Bed Hold Policy and Involuntary Transfer form with the resident.
10. Following ambulance pick-up of the resident, the primary nurse is to contact the ER Nurse receiving the resident by telephone, and give report. Include above information in addition to identifying self as primary nurse, with phone

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number for follow up.
11. Notify DON of the resident's transfer.
12. Report on 24-hour report.
13. Write discharge note. Include: A. Notification of family. B. Reason for transfer. C. Areas noted per #7 above. D. Status of resident's belongings.
(Section on non-emergency transfers)
Please note: Notification of Involuntary Transfers from the facility must be sent to the Ombudsman. Coordinate with local Ombudsman to determine communication frequency. Must be at least monthly.

1. Resident #91 was admitted to the facility on 5/21/21 with the diagnoses of but not limited to COVID-19, stroke, high blood pressure, chronic kidney disease, end stage renal disease and congestive heart failure. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/13/21. Resident #91 was coded as cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 10/26/21 at 2:47 PM that documented, "Pt (patient) went out for dialysis @ (at) 9am and came back at 2:15pm very weak. Pt was assessed by MD (medical doctor) new order to send Pt to ER (emergency room) for confusion post dialysis."

A nurse's note dated 10/26/21 at 9:22 PM documented, "Resident return from (hospital) with no discharge paper work, Spoke with charge nurse ad she stated she would fax (fax number)."

Further review of the clinical record failed to

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evidence that the physician wrote a note documenting the rationale for Resident #91's hospital transfer, the specific resident need(s) that could not be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the residents need(s).

There was no evidence in the clinical record regarding any transfer documents or paperwork completed prior to transfer and what documentation, if any, was provided to the hospital for this transfer.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face sheet, physician order summary, current labs [laboratory tests], bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM (Administrative Staff Member) #1 (the Administrator), ASM #2 (the Director of Nursing), ASM #4 (the Regional Director of Clinical), and ASM #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the

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facility did not have anything regarding the hospital transfer for Resident #91.

No further information was provided by the end of the survey.

2. Resident #49 was admitted to the facility on 5/27/21 with the diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, dementia, chronic kidney disease, morbid obesity, high blood pressure, atrial fibrillation, breast and skin cancer, and sleep apnea. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 10/26/21. Resident #49 was coded as cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 8/19/21 at 9:35 PM that documented, "Change of shift @ (at) 3:15 pm, pt (patient) was unable to verbally express herself, temp (temperature) was 100.9, BP (blood pressure) 90/52, O2 (oxygen) sat (saturation) 89% on 3lpm nc (3 liters per minute via nasal cannula) O2, BLE's (bilateral lower extremities) extremely swollen and RLE (right lower extremity) grayish white, LLE (left lower extremity) purplish from the knee down which is new. Daughter notified. Administrator notified as well as DON (Director of Nursing). Resident is DNR (Do Not Resuscitate). All in agreement to transfer to (hospital) with order from NP (nurse practitioner.)"

A nurse's note dated 8/23/21 at 10:25 PM documented in part, "Resident arrived via transport from (hospital). Resident alert and not

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happy to be back per her words. Total assist to get in the bed..."

Further review of the clinical record failed to evidence that the physician wrote a note documenting the rationale for the transfer, the specific resident need(s) that could not be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the residents need(s).

There was no evidence in the clinical record regarding any transfer documents or paperwork completed prior to the 8/19/21, hospital transfer and what documentation, if any, was provided to the hospital for this transfer.

A nurse's note dated 9/1/21 at 2:40 PM documented, "STAT (immediate) labs [laboratory tests] ordered obtained and sent to lab, cxr (chest x-ray) done, Called (x-ray company) to set up echocardiogram, they will call back to schedule. If pt has hypoxia, pulse ox less than 92% on O2 (oxygen) @ (at) 2 liter/min (liters per minute) or if has dyspnea or increase AMS (altered mental status) transport to ER (emergency room) per MD (medical doctor)."

A physician's progress note dated 9/4/21 at 6:59 PM documented, "....The patient had been hospitalized for acute CHF (congestive heart failure) exacerbation and lymphedema. She was evaluated by (Hospice Company) but was recommended to come back to our facility for rehab [rehabilitation], and then the family plan is to admit her to hospice...."

There was no evidence in the clinical record regarding any transfer documents or paperwork

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completed prior to the 9/1/2021, hospital transfer and what documentation, if any, was provided to the hospital for this transfer.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face sheet, physician order summary, current labs, and bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM (Administrative Staff Member) #1 (the Administrator), ASM #2 (the Director of Nursing), ASM #4 (the Regional Director of Clinical), and ASM #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #49.

No further information was provided by the end of the survey.

3. Resident #26 was admitted to the facility on

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4/5/21 with the diagnoses of but not limited to stroke, respiratory failure, diabetes, COVID-19, morbid obesity, chronic kidney disease, congestive heart failure, high blood pressure, and alcohol abuse. In addition, Resident #26 was readmitted to the facility on 9/14/21 status post a scheduled surgery of the carotid artery. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 9/24/21. Resident #26 was coded as being cognitively intact in ability to make daily life decisions.

A nurse's note dated 9/15/21 at 10:26 PM documented, "Resident had c/o (complained of) involuntary movement of the right arm. Upon evaluation, residents VS (vital signs) were stable with no s/s (signs or symptoms) of any neurological deficit. Resident was very anxious. NP (nurse practitioner) was contacted c (with) VS and instructed staff to monitor patient....Approximately an hour and a half later, resident was still complaining of involuntary movement. Resident appeared to be feeling better and her anxiety level had decreased. Resident insisted that something was wrong. Nurse contacted NP for further orders. Orders to send resident to ER. 911 called, resident left center at 8:05pm."

Resident #26 was readmitted to the facility from the hospital on 9/22/21.

A physician's progress note dated 9/26/21 at 6:04 AM documented, "....The patient has returned from (hospital) following a probable CVA (stroke) as a untoward event following her left carotid stenosis repair with stent placement....She will continue f/u (follow up) with vascular surgery...."

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Review of the clinical record failed to evidence any transfer documents or paperwork completed prior to the 9/15/21, hospital transfer and what documentation, if any, was provided to the hospital for this transfer.

A physician's progress note dated 11/3/21 at 8:19 AM documented, "....She is continuing to have intermittent GI (gastrointestinal) bleeding from both internal and external hemorrhoids, which frequently requires transfer to the ER [emergency room] / admission. She has had banding of hemorrhoids, and is planning for further surgical procedures...."

A nurse's note dated 11/4/21 at 11:45 AM documented, "Resident sent to ER for rectal bleeding."

A nurse's note dated 11/5/21 at 5:08 AM documented, "Resident returned from hospital. Report given from EMT (emergency medical technician)....They kept an eye on bleeding which did not continue so resident was discharged. If problems with hemorrhoids again resident is to schedule apt (appointment) with primary care doctor."

Review of the clinical record failed to evidence any transfer documents or paperwork completed prior to the 11/04/21, hospital transfer and what documentation, if any, was provided to the hospital for this transfer.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face

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sheet, physician order summary, current labs, and bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM (Administrative Staff Member) #1 (the Administrator), ASM #2 (the Director of Nursing), ASM #4 (the Regional Director of Clinical), and ASM #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #26.

No further information was provided by the end of the survey.

4. Resident #29 was admitted to the facility with diagnoses that included but were not limited to sepsis (1) and gastrostomy (2). Resident #29's most recent MDS, a quarterly assessment with an ARD of 9/3/2021, coded Resident #29 as being moderately impaired for making daily decisions.

The progress notes for Resident #29 documented in part,

- "10/23/2021 21:30 (9:30 p.m.) Late Entry: Note Text: While doing rounds, I noticed brown and clear drainage from resident's G-tube

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(gastrostomy tube). Tube seem to be leaking from somewhere. Resident's gown and bed was soaked. Per aid [Name of staff member], this was happening all day. Resident seem to be in more pain than usual, and more uncomfortable than usual. Feeding was stopped. Tube flushed well, and meds were given through tube in attempt to provide a little comfort. Called [Name of staff member], NP (nurse practitioner) for guidance. [Name of NP] told me to call the family and ask if they wanted me to send resident to the hospital because she would not be able to look at the tube until Monday. Spoke with family member and made the decision to go ahead and sent resident to the hospital."

- "11/17/2021 17:15 (5:15 p.m.) Note Text: Resident arrived at facility @ 1530 via (at 3:30 p.m. by) transport. Residents orders have been NP notified. Resident is now DNR (do not resuscitate) vitals were taken and resident is in [Room number]. Kangaroo pump (feeding tube pump) set up. Resident currently resting with no complications or s/s (signs/symptoms) of pain or discomfort."

The clinical record failed to evidence documentation of information provided to the hospital on 10/23/2021 for Resident #29's transfer.

On 11/30/2021 at approximately 4:30 p.m., a request was made by written list to ASM (administrative staff member) #1, the interim administrator for evidence of the documents provided to the receiving facility for the transfer of Resident #29 on 10/23/2021.

On 12/1/2021 at approximately 5:00 p.m., ASM

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#4, the regional director of clinical operations stated that they did not have any documents to provide for Resident #29.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face sheet, physician order summary, current labs, and bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated that they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/1/2021 at approximately 5:30 p.m., a request was made to ASM (administrative staff member) #1 for the facility policy for transfers and discharges.

On 12/1/2021 at approximately 5:10 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were made aware of the findings.

No further information was provided prior to exit.

References:

1. Sepsis: An illness in which the body has a severe, inflammatory response to bacteria or

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other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: <https://medlineplus.gov/ency/article/000666.htm >.

2. Gastrostomy (G-Tube): A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm.

5. Resident #13 was admitted to the facility with diagnoses that included but were not limited to cellulitis (1) and dementia (2). Resident #13's most recent MDS, a significant change assessment with an ARD (assessment reference date) of 9/7/2021, coded Resident #13 as scoring a 3 on the BIMS- brief interview for mental status, 3- being severely impaired for making daily decisions.

The progress notes for Resident #13 documented in part, that Resident #13 was transferred to the hospital on 8/19/21 at approximately 20:55 (8:55 p.m.) after staff found the resident on the floor with 2x2cm (centimeters) of bleeding to the scalp and complaints of head pain and was readmitted to the facility on 8/24/21.

Further review of the clinical record failed to evidence documentation of the information provided to the receiving hospital on 8/19/2021 for Resident #13.

On 11/30/2021 at approximately 4:30 p.m., a request was made by written list to ASM

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(administrative staff member) #1, the interim administrator for evidence of the documents provided to the receiving facility for the transfer on 8/19/2021 for Resident #13.

On 12/1/2021 at approximately 5:00 p.m., ASM #4, the regional director of clinical operations stated that they did not have any documents to provide for Resident #13.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face sheet, physician order summary, current labs, and bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/1/2021 at approximately 5:10 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were made aware of the findings.

No further information was provided prior to exit.

References:

1. Cellulitis: A common skin infection caused by

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F 622	Continued From page 43 bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected. This information was obtained from the website: https://medlineplus.gov/ency/article/000855.htm. 2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623	**F623** 1. Resident #91 and #100 are no longer in the center. Resident's #49, #26, #29, and #13 remains safely in the center and have not had a transfer within the last 30 days. 2. Residents in the center that have been transferred within the last 30 days have the potential to be affected. These residents were reviewed for notification to the Ombudsman and written notification to the Resident Representative and no issues with notification noted.	

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F 623	Continued From page 44 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623	3. The DON/designee provided re-education to the Social Services team regarding the notification to the Ombudsman and written notification being sent to the Resident representative. 4. Transfers will be audited weekly for 1 month to ensure there is notification to the Ombudsman and written notification to the Resident representative. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date 01/04/22	

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developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence that written notification of a hospital transfer was provided to the Ombudsman and/or Resident Representative upon a hospital transfer for six of 46 residents in the survey sample; Residents #91, #49, #26, #29, #13 and #100.

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The facility staff failed to evidence that written notification was provided to the resident representative and Ombudsman for Resident #91's hospital transfer on 10/26/21, Resident #49's hospital transfers on 8/19/21 and 9/1/21, Resident #26's hospital transfer on 9/15/21 and 11/4/21, Resident #29's hospital transfer on 10/23/2021, Resident #13's hospital transfer on 8/19/21, and Resident #100's hospital transfer on 11/1/2021.

The findings include:

A review of the facility policy, "Transfer a Resident to a Hospital" documented in part, "....6. Notify the family or responsible party of the pending transfer, and the reasons for the move....13. Write discharge note. Include: A. Notification of family. B. Reason for transfer. C. Areas noted per #7 above. D. Status of resident's belongings....Please note: Notification of Involuntary Transfers from the facility must be sent to the Ombudsman. Coordinate with local Ombudsman to determine communication frequency. Must be at least monthly."

1. Resident #91 was admitted to the facility on 5/21/21 with the diagnoses of but not limited to COVID-19, stroke, high blood pressure, chronic kidney disease, end stage renal disease and congestive heart failure. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 11/13/21. Resident #91 was coded as being cognitively impaired in ability to make daily life decisions.

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A review of the clinical record revealed a nurse's note dated 10/26/21 at 2:47 PM that documented, "Pt (patient) went out for dialysis @ (at) 9am and came back at 2:15pm very weak. Pt was assessed by MD (medical doctor) new order to send Pt to ER (emergency room) for confusion post dialysis."

Further review of the clinical record failed to evidence written notification regarding Resident #91's hospital transfer to the resident's representative and Ombudsman.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated it was the responsibility of the facility to follow up with the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM #8 stated that they were unsure of the process because they were new to the facility and would have to check on this. OSM #8 stated they notified the ombudsman of discharges by fax weekly but had not sent any since they had started working at the facility.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM Administrative Staff Member) #1 (the Interim Administrator), #2 (the Director of Nursing), #4 (the Regional Director of Clinical), and #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #91.

No further information was provided by the end of the survey.

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2. Resident #49 was admitted to the facility on 5/27/21 with the diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, dementia, chronic kidney disease, morbid obesity, high blood pressure, atrial fibrillation, breast and skin cancer, and sleep apnea. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 10/26/21. Resident #49 was coded as cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 8/19/21 at 9:35 PM that documented, "Change of shift @ (at) 3:15 pm, pt (patient) was unable to verbally express herself, temp (temperature) was 100.9, BP (blood pressure) 90/52, O2 (oxygen) sat (saturation) 89% on 3lpm nc (3 liters per minute via nasal cannula) O2, BLE's (bilateral lower extremities) extremely swollen and RLE (right lower extremity) grayish white, LLE (left lower extremity) purplish from the knee down which is new. Daughter notified. Administrator notified as well as DON (Director of Nursing). Resident is DNR (Do Not Resuscitate). All in agreement to transfer to (hospital) with order from NP (nurse practitioner.)"

Further review of the clinical record failed to evidence written notification regarding Resident #49's hospital transfer to the resident's representative and Ombudsman.

A nurse's note dated 9/1/21 at 2:40 PM documented, "STAT (immediate) labs ordered obtained and sent to lab, cxr (chest x-ray) done. Called (x-ray company) to set up echocardiogram, they will call back to schedule.

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If pt has hypoxia, pulse ox less than 92% on O2 (oxygen) @ (at) 2 liter/min (liters per minute) or if has dyspnea or increase AMS (altered mental status) transport to ER (emergency room) per MD (medical doctor)."

A physician's progress note dated 9/4/21 at 6:59 PM documented, "....The patient had been hospitalized for acute CHF (congestive heart failure) exacerbation and lymphedema. She was evaluated by (Hospice Company) but was recommended to come back to our facility for rehab [rehabilitation], and then the family plan is to admit her to hospice...."

Further review of the clinical record failed to evidence written notification regarding Resident #49's hospital transfer to the resident's representative and Ombudsman.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated it was the responsibility of the facility to follow up with the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM #8 stated they were unsure of the process because they were new to the facility and would have to check on this. OSM #8 stated that they notified the ombudsman of discharges by fax weekly but had not sent any since they had started working at the facility.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM Administrative Staff Member) #1 (the Interim Administrator), #2 (the Director of Nursing), #4 (the Regional Director of Clinical), and #5 (the Regional Vice President of

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Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #49.

No further information was provided by the end of the survey.

3. Resident #26 was admitted to the facility on 4/5/21 with the diagnoses of but not limited to stroke, respiratory failure, diabetes, COVID-19, morbid obesity, chronic kidney disease, congestive heart failure, high blood pressure, and alcohol abuse. Resident #26 was readmitted on 9/14/21 status post a scheduled surgery of the carotid artery. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 9/24/21. Resident #26 was coded as being cognitively intact in ability to make daily life decisions.

A nurse's note dated 9/15/21 at 10:26 PM documented, "Resident had c/o (complained of) involuntary movement of the right arm. Upon evaluation, residents VS (vital signs) were stable with no s/s (signs or symptoms) of any neurological deficit. Resident was very anxious. NP (nurse practitioner) was contacted c (with) VS and instructed staff to monitor patient....Approximately an hour and a half later, resident was still complaining of involuntary movement. Resident appeared to be feeling better and her anxiety level had decreased. Resident insisted that something was wrong. Nurse contacted NP for further orders. Orders to send resident to ER. 911 called, resident left center at 8:05pm."

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Resident #26 was readmitted to the nursing facility on 9/22/21.

A physician's progress note dated 9/26/21 at 6:04 AM documented, "....The patient has returned from (hospital) following a probable CVA (cerebrovascular accident) as a untoward event following her left carotid stenosis repair with stent placement....She will continue f/u (follow up) with vascular surgery...."

There was no evidence in the clinical record of written notification to the resident's representative and Ombudsman regarding Resident #26's hospital transfer.

A physician's progress note dated 11/3/21 at 8:19 AM documented, "....She is continuing to have intermittent GI (gastrointestinal) bleeding from both internal and external hemorrhoids, which frequently requires transfer to the ER / admission. She has had banding of hemorrhoids, and is planning for further surgical procedures...."

A nurse's note dated 11/4/21 at 11:45 AM documented, "Resident sent to ER for rectal bleeding."

There was no evidence in the clinical record written notification to the resident's representative and Ombudsman regarding Resident #26's hospital transfer.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated it was the responsibility of the facility to follow up with

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the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM #8 stated they were unsure of the process because they were new to the facility and would have to check on this. OSM #8 stated that they notified the ombudsman of discharges by fax weekly but had not sent any since they had started working at the facility.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM Administrative Staff Member) #1 (the Interim Administrator), #2 (the Director of Nursing), #4 (the Regional Director of Clinical), and #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #26.

No further information was provided by the end of the survey.

4. Resident #29 was admitted to the facility with diagnoses that included but were not limited to sepsis (1) and gastrostomy (2). Resident #29's most recent MDS, a quarterly assessment with an ARD of 9/3/2021, coded Resident #29 as being moderately impaired for making daily decisions.

The progress notes for Resident #29 documented in part the following:

- "10/23/2021 21:30 (9:30 p.m.) Late Entry: Note Text: While doing rounds, I noticed brown and clear drainage from resident's G-tube (gastrostomy tube). Tube seem to be leaking from somewhere. Resident's gown and bed was soaked. Per aid [Name of staff member], this was happening all day. Resident seem to be in more

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pain than usual, and more uncomfortable than usual. Feeding was stopped. Tube flushed well, and meds were given through tube in attempt to provide a little comfort. Called [Name of staff member], NP (nurse practitioner) for guidance. [Name of NP] told me to call the family and ask if they wanted me to send resident to the hospital because she would not be able to look at the tube until Monday. Spoke with family member and made the decision to go ahead and sent resident to the hospital."

Further review of the clinical record failed to evidence documentation of written notification provided to the responsible party or the ombudsman for the transfer on 10/23/2021 for Resident #29.

On 11/30/2021 at approximately 4:30 p.m., a request was made by written list to ASM (administrative staff member) #1, the interim administrator for evidence of written notification provided to the responsible party and the ombudsman for the transfer on 10/23/2021 for Resident #29.

On 12/1/2021 at approximately 1:38 p.m., ASM #1 stated that they did not have evidence of ombudsman notification of the transfer on 10/23/2021 for Resident #29.

On 12/1/2021 at 4:25 p.m., ASM #1 provided via email a copy of the progress note dated 10/23/2021 documenting verbal notification of the responsible party of the transfer on 10/23/2021.

On 12/1/2021 at approximately 5:00 p.m., a request was made for evidence of written notification of the responsible party for the

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transfer on 10/23/2021 for Resident #29. ASM #4, the regional director of clinical operations stated that they did not have any additional documents to provide for Resident #29.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated that it was the responsibility of the facility to follow up with the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM #8 stated that they were unsure of the process because they were new to the facility and would have to check on this. OSM #8 stated that they notified the ombudsman of discharges by fax weekly but had not sent any since they had started working at the facility.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face sheet, physician order summary, current labs, and bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/1/2021 at approximately 5:10 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of

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clinical operations and ASM #5, the regional vice president of operations were made aware of the findings.

No further information was provided prior to exit.

References:

1. Sepsis: An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: <https://medlineplus.gov/ency/article/000666.htm>.

2. Gastrostomy (G-Tube): A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm.

5. Resident #13 was admitted to the facility with diagnoses that included but were not limited to cellulitis (1) and dementia (2). Resident #13's most recent MDS, a significant change assessment with an ARD of 9/7/2021, coded Resident #13 as scoring a 3 on the BIMS- brief interview for mental status, 3- being severely impaired for making daily decisions.

The progress notes for Resident #13 documented in part, that Resident #13 was transferred to the hospital on 8/19/21 at approximately 20:55 (8:55 p.m.) after staff found the resident on the floor with 2x2cm (centimeters) of bleeding to the scalp and complaints of head pain and was readmitted

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#8 stated that they were unsure of the process because they were new to the facility and would have to check on this. OSM #8 stated that they notified the ombudsman of discharges by fax weekly but had not sent any since they had started working at the facility.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face sheet, physician order summary, current labs, and bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/1/2021 at approximately 5:10 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were made aware of the findings.

No further information was provided prior to exit.

References:

1. Cellulitis: A common skin infection caused by bacteria. It affects the middle layer of the skin (dermis) and the tissues below. Sometimes, muscle can be affected. This information was

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to the facility on 8/24/21.

The clinical record failed to evidence documentation of written notification of the responsible party or the ombudsman for the transfer on 8/19/2021 for Resident #13.

On 11/30/2021 at approximately 4:30 p.m., a request was made by written list to ASM (administrative staff member) #1, the interim administrator for evidence of the written notification provided to the responsible party and the ombudsman for the transfer on 8/19/2021 for Resident #13.

On 12/1/2021 at approximately 1:38 p.m., ASM #1 stated that they did not have evidence of ombudsman notification of the transfer on 8/19/2021.

On 12/1/2021 at 4:25 p.m., ASM #1 provided via email a copy of the progress note dated 8/19/2021 documenting verbal notification of the responsible party of the transfer on 8/19/2021.

On 12/1/2021 at approximately 5:00 p.m., a request was made for written notification to the responsible party of the transfer on 8/19/2021. ASM #4, the regional director of clinical operations stated that they did not have any additional documentation to provide for Resident #13.

On 12/2/2021 at 8:25 a.m., an interview was conducted with OSM (other staff member) #8, director of social services. OSM #8 stated that it was the responsibility of the facility to follow up with the resident or responsible party within 24 hours to see if they wanted to hold the bed. OSM

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obtained from the website: https://medlineplus.gov/ency/article/000855.htm.

2. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

6. Resident #100 was admitted to the facility with diagnoses that included but were not limited to Parkinson's disease (1) and dysphagia (2). Resident #100's most recent MDS, a quarterly assessment with an ARD of 9/10/2021, coded Resident #100 as scoring a 14 on the BIMS- brief interview for mental status, 14- being cognitively intact for making daily decisions.

The progress notes for Resident #100 documented in part, "11/12/2021 19:19 (7:19 p.m.) Note Text: Resident sent out per [Name of nurse practitioner] to [Name of hospital] for evaluation and treatment. Skin-has buttocks open area. [Names of emergency contacts] both were made aware."

The clinical record failed to evidence documentation of written notification provided to the resident/responsible party for the transfer on 11/1/2021 for Resident #100.

On 12/02/2021 at approximately 8:00 a.m., a request was made by written list to ASM (administrative staff member) #1, the interim administrator for evidence of written notification of the responsible party and the ombudsman for the facility initiated transfer on 11/1/2021.

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On 12/2/2021 at approximately 9:57 a.m., ASM #1 stated that they did not have evidence of written notification of the responsible party for the transfer on 11/1/2021 and provided evidence of ombudsman notification faxed on 12/2/2021.

On 12/2/2021 at 8:30 a.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked about the process for hospital transfers, LPN #1 stated that they sent a face sheet, physician order summary, current labs, and bed hold notice, notice of transfer and SBAR (situation, background, assessment, recommendation) to the hospital with residents. LPN #1 stated they also call a full verbal report to the emergency room. LPN #1 stated they contact the responsible party to notify of the discharge and send a written discharge notification in the paperwork to the hospital. LPN #1 stated that they were supposed to keep a copy of these documents and place it in the front of the chart to evidence that this information was sent.

On 12/2/2021 at approximately 10:09 a.m., ASM #1, the interim administrator and ASM #4, the regional director of clinical operations were made aware of the findings.

No further information was provided prior to exit.

References:

1. Parkinson's disease: A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

2. Dysphagia: A swallowing disorder. This

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F 623	Continued From page 60 information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was	F 625	**F625** 1. Resident #49, #26 and #68 remain safely in the center and have not had a transfer within the last 30 days. 2. Residents in the center that have been transferred within the last 30 days have the potential to be affected. These residents were reviewed and no issues with being provided bed hold policy identified. 3. The DON/designee provided re-education to the Social Services and Business Office associates regarding the Transfer to Hospital policy related to bed holds. 4. Transfers will be audited weekly for 1 month to ensure there is of the bed hold policy. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.	

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determined that the facility staff failed to evidence that a written bed hold notice was provided to the resident and/or resident representative prior to and or at the time of transfer to the hospital for three of 46 residents in the survey sample; Residents #49, #26 and #68.

The facility staff failed to evidence that a written bed hold notice was provided to the resident and or resident representative for the hospital transfers of Resident #49 on 8/19/21 and 9/1/21, Resident #26 on 9/2/2021 and Resident #68 on 10/27/21.

The findings include:

A review of the facility policy, "Transfer a Resident to a Hospital" documented, "Emergency Transfer....9. Send a copy of Bed Hold Policy and Involuntary Transfer form with the resident."

1. Resident #49 was admitted to the facility on 5/27/21 with the diagnoses of but not limited to congestive heart failure, chronic obstructive pulmonary disease, dementia, chronic kidney disease, morbid obesity, high blood pressure, atrial fibrillation, breast and skin cancer, and sleep apnea. The most recent MDS (Minimum Data Set) was a significant change assessment with an ARD (Assessment Reference Date) of 10/26/21. The resident was coded as cognitively impaired in ability to make daily life decisions.

A review of the clinical record revealed a nurse's note dated 8/19/21 at 9:35 PM that documented, "Change of shift @ (at) 3:15 pm, pt (patient) was unable to verbally express herself, temp (temperature) was 100.9, BP (blood pressure) 90/52, O2 (oxygen) sat (saturation) 89% on 3lpm

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nc (3 liters per minute via nasal cannula) O2, BLE's (bilateral lower extremities) extremely swollen and RLE (right lower extremity) grayish white, LLE (left lower extremity) purplish from the knee down which is new. Daughter notified. Administrator notified as well as DON (Director of Nursing). Resident is DNR (Do Not Resuscitate). All in agreement to transfer to (hospital) with order from NP (nurse practitioner.)"

Further review of the clinical record failed to evidence that a written bed hold notice was provided to Resident #49 and or the resident representative prior to and or at the time of transfer to the hospital on 8/19/21.

A nurse's note dated 9/1/21 at 2:40 PM documented, "STAT (immediate) labs [laboratory tests] ordered obtained and sent to lab, cxr (chest x-ray) done, Called (x-ray company) to set up echocardiogram, they will call back to schedule. If pt has hypoxia, pulse ox less than 92% on O2 (oxygen) @ (at) 2 liter/min (liters per minute) or if has dyspnea or increase AMS (altered mental status) transport to ER (emergency room) per MD (medical doctor)."

A physician's progress note dated 9/4/21 at 6:59 PM documented, "....The patient had been hospitalized for acute CHF (congestive heart failure) exacerbation and lymphedema. She was evaluated by (Hospice Company) but was recommended to come back to our facility for rehab [rehabilitation], and then the family plan is to admit her to hospice...."

There was no evidence in the clinical record that a written bed hold notice was provided with this hospital transfer.

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On 12/2/2021 at 9:10 a.m., an interview was conducted with OSM (other staff member) #10, social services assistant. OSM #10 stated that the bed hold policy was given to residents or responsible parties on admission to review and sign. OSM #10 stated that a copy of this was kept in the residents chart. OSM #10 stated that when a resident went to a hospital a bed hold form was completed and sent along with the resident transfer sheet. OSM #10 stated that a copy of the form was kept in a binder in the social services office and a follow up phone call the next day to see if a bed hold is requested. OSM #10 stated that they were new to the facility and had not completed a bed hold as of today but their process was to keep a copy of any letters sent out and a binder with the bed hold notices in them. OSM #10 stated that there was an existing binder for the bed hold notices but there was a gap in them when there was a change in social workers.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM Administrative Staff Member) #1 (the Interim Administrator), #2 (the Director of Nursing), #4 (the Regional Director of Clinical), and #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #49.

No further information was provided by the end of the survey.

2. Resident #26 was admitted to the facility on

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4/5/21 with the diagnoses of but not limited to stroke, respiratory failure, diabetes, COVID-19, morbid obesity, chronic kidney disease, congestive heart failure, high blood pressure, and alcohol abuse. Resident #26 was readmitted on 9/14/21 status post a scheduled surgery of the carotid artery. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 9/24/21. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as being independent for all areas of activities of daily living.

A nurse's note dated 9/15/21 at 10:26 PM documented, "Resident had c/o (complained of) involuntary movement of the right arm. Upon evaluation, residents VS (vital signs) were stable with no s/s (signs or symptoms) of any neurological deficit. Resident was very anxious. NP (nurse practitioner) was contacted c (with) VS and instructed staff to monitor patient....Approximately an hour and a half later, resident was still complaining of involuntary movement. Resident appeared to be feeling better and her anxiety level had decreased. Resident insisted that something was wrong. Nurse contacted NP for further orders. Orders to send resident to ER. 911 called, resident left center at 8:05pm."

Resident #26 was readmitted to the nursing facility on 9/22/21.

A physician's progress note dated 9/26/21 at 6:04 AM documented, "....The patient has returned from (hospital) following a probable CVA (stroke) as a untoward event following her left carotid stenosis repair with stent placement....She will

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continue f/u (follow up) with vascular surgery...."

There was no evidence in the clinical record that a written bed hold notice was provided to the resident and or resident representative for this hospital transfer.

On 12/2/2021 at 9:10 a.m., an interview was conducted with OSM #10, social services assistant. OSM #10 stated that the bed hold policy was given to residents or responsible parties on admission to review and sign. OSM #10 stated that a copy of this was kept in the residents chart. OSM #10 stated that when a resident went to a hospital a bed hold form was completed and sent along with the resident transfer sheet. OSM #10 stated that a copy of the form was kept in a binder in the social services office and a follow up phone call the next day to see if a bed hold is requested. OSM #10 stated that they were new to the facility and had not completed a bed hold as of today but their process was to keep a copy of any letters sent out and a binder with the bed hold notices in them. OSM #10 stated that there was an existing binder for the bed hold notices but there was a gap in them when there was a change in social workers.

On 12/1/21 at approximately 5:00 PM at the end of day meeting with ASM Administrative Staff Member) #1 (the Interim Administrator), #2 (the Director of Nursing), #4 (the Regional Director of Clinical), and #5 (the Regional Vice President of Operations) were made aware of the findings.

On 12/2/21 at 8:05 AM, ASM #1 stated that the facility did not have anything regarding the hospital transfer for Resident #26.

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No further information was provided by the end of the survey.
3. Resident #68 was admitted to the facility on 7/11/19. Resident #68's diagnoses included but were not limited to: diabetes mellitus (inability of insulin to function normally in the body) (1), sepsis (life threatening organ dysfunction caused by deregulated response to infection) (2) and atrial fibrillation (rapid, random contraction of the upper portion of the heart) (3).

Resident #68's most recent MDS (minimum data set) assessment, a quarterly and five day assessment, with an assessment reference date of 11/6/21, coded the resident as scoring 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact.

A review of the comprehensive care plan revised 9/27/21, documented in part, "FOCUS: Alteration in elimination of bowel and bladder incontinence, constipation history of urinary tract infections. I will be free of urinary tract infections through the next review period. INTERVENTION: Encourage fluids. Monitor and report S&S [signs and symptoms] of UTI [urinary tract infection]: changes in color, odor, or consistency of urine, dysuria, frequency, fever, pain."

A review of the resident transfer form dated 10/27/21, documented in part, "Fever, altered level of consciousness. Transfer to hospital."

A review of the nursing progress note dated 10/27/21 at 10:35 PM, documented in part, "Entered room at approximately 9:45 PM for medication pass, observed client to be flushed

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and altered mental status. Temperature-105.3 pulse-130 respirations-22 blood pressure-151/101 unable to acquire oxygen saturation due to client restlessness and removing monitor. Notified nurse practitioner notified of client status and order to send to hospital for evaluation. Resident is own RP (responsible party). Rescue squad arrived approximately 10:15 PM. Informed of client's limited mobility and refusal of care. Evaluation and transfer to stretcher via slide board. Resident left at approximately 10:30 PM. Report called to hospital."

No additional progress note or form documenting a bed hold notice was provided to the resident and or resident representative was evidenced in the medical record.

Request for evidence of documentation was returned on 12/1/21 at 8:15 AM by ASM (administrative staff member) #1, the interim administrator, who verbally stated, "There is no evidence of bed hold for this resident."

An interview was conducted on 12/2/21 at 8:10 AM with ASM #1. When asked, who does bed holds, ASM #1 stated, "That's a good question, I don't know who is doing that."

An interview was conducted on 12/2/21 at 8:25 AM with OSM (other staff member) #8, the social services director. When asked who was responsible for completing bed holds, OSM #8 stated, "Social Services is responsible for the bed hold." When asked about the process followed, OSM #8 stated, "The facility follows up with the patient or family within 24 hours to see if they want to hold the bed." When asked how that

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process occurs and what evidence there is that it was completed, OSM #8 stated, "I'll have to get back with you. I've been here for 10 days and I haven't done social services at other facilities. I have a social services assistant has been here longer than I have and she will come into talk with you about the bed hold."

An interview was conducted on 12/2/21 at 9:10 AM with OSM #10, the social services assistant. When asked when she started, OSM #10 stated, "I started November 8, 2021." When asked about the bed hold process, OSM #10 stated, "Upon admission the resident or RP (responsible party) is given the bed hold policy to sign and a copy is kept in their chart. If they go to the hospital then a bed hold form is done. I keep everything in a binder since I have been here. I contact the patient or family the next morning to find out about the bed hold. I have not had any transfers to hospital since I have been here, but I would document in the chart that the bed hold was done, I keep copies of letters we mail out and faxes about bed holds in the binder."

On 12/1/21 at 5:00 PM, ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were informed of the findings.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160.

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F 625	Continued From page 69 (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 524. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 54.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interview, it was determined that the facility staff failed to ensure an accurate MDS [minimum data set] assessment for one of 46 residents in the survey sample, Resident # 86. The facility staff failed to code Resident # 86 for the use of oxygen in Section O "Special Treatments" on the residents 5 day MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/05/2021. The findings include: Resident # 86 was admitted to the facility with diagnoses that included but were not limited to: shortness of breath, respiratory failure [1], and congestive heart failure [2]. Resident # 86's most recent MDS (minimum data set), a 5-day assessment with an ARD (assessment reference date) of 11/05/2021, coded Resident # 86 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0	F 641	**F641** 1. Resident #86 remain safely in the center and assessment has been updated to accurately reflect the resident status. 2. Residents in the center that have oxygen have the potential to be affected. These residents were reviewed and no issues with accurate MDS coding noted. 3. The DON/designee provided re-education to the MDS team related to the accuracy of assessments. 4. New admissions with oxygen will be audited weekly for 1 month to ensure accurate coding for oxygen use if appropriate. Results will be presented to QAPI monthly.	

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- 15, 10 - being moderately impaired of cognition for making daily decisions. Section O "Special Treatments, Procedures and Programs" failed to code Resident # 86 for the use of oxygen.

On 11/29/21 at approximately 3:45 P.M., an observation of Resident # 86 revealed the resident lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on the oxygen concentrator revealed Resident # 86 was receiving oxygen at three liters per minute.

The comprehensive care plan for Resident # 86 dated 01/28/2020 documented. "FOCUS: I have alteration in Respiratory Status Due to Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, risk for shortness of Breath and hx [history] of respiratory failure with hypoxia. Date Initiated: 01/28/2020." Under "Interventions" it documented in part, "Administer oxygen at 3 lpm [liters per minute] via [by] nasal cannula per Physician order. Monitor oxygen saturations on room air and/or oxygen. Monitor oxygen flow rate and response. Date Initiated: 01/28/2020. Revision on: 03/31/2020."

The physician's order for Resident # 86 documented, "O2 [oxygen] at 3L [three liters] via [by] NC [nasal cannula] continuously every shift for chf [congestive heart failure]. Order Date: 3/26/2020."

On 11/30/2021 at approximately 3:35 p.m., an interview was conducted with RN [registered nurse] # 1, MDS coordinator. RN #1 reviewed Resident # 86's MDS assessment with an ARD of 11/05/2021, the comprehensive care plan dated 01/28/2020, and the physician's order for

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Resident # 86's oxygen and was informed of the above observation. RN #1 then stated, "Oxygen should have been coded on the MDS." When asked what she uses as guidance for completing the MDS assessment, RN # 1 stated she uses the RAI (Resident Assessment Instrument) manual.

CMS's (Centers for Medicare/Medicaid Services) Long-Term Care RAI (Resident Assessment Instrument) Version 3.0 Manual documented, "O0100: Special Treatments, Procedures, and Programs (cont.) O0100C, Oxygen therapy. Code continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia in this item. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here. Do not code hyperbaric oxygen for wound therapy in this item. This item may be coded if the resident places or removes his/her own oxygen mask, cannula."

On 12/01/2021 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the interim administrator, ASM # 2, director of nursing, ASM # 4, director of clinical operations and ASM # 5, regional vice president of operations, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

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F 641	Continued From page 72 [2] A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	**F656** 1. Resident #62 remains safely in the center. The comprehensive care plan is being implemented for keeping the catheter collection bag off the floor and administering oxygen at two liters per minutes. 2. Current residents in the center that have catheters and are on oxygen have the potential to be affected. These residents were reviewed and no issues noted. 3. The DON/designee provided re-education to current licensed nurses, current CNA's in the center, and the current IDT team in the center regarding implementing a comprehensive care plan.	

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F 656	Continued From page 73	F 656	4. Room rounds will be conducted 5x a week for 1 month to ensure comprehensive care plan is implemented for catheter bags and oxygen. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date 01/04/22	

resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for one of 46 residents in the survey sample, Resident # 62.

The facility staff failed implement Resident # 62's comprehensive care plan to keep the catheter collection bag off the floor and failed implement Resident # 62's comprehensive care plan to administer oxygen at two liters per minute.

The findings include:

Resident # 62 was admitted to the facility with diagnoses that included but were not limited to: obstructive uropathy [1]. Resident # 62's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/02/2021, coded Resident # 62 as scoring a 9 [nine] on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 - being moderately impaired of cognition for making daily decisions. Section H "Bladder and Bowel" coded

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Resident # 62 as having an indwelling catheter.

Observations of Resident # 62 on 11/30/21 at approximately 8:45 a.m., 10:17 a.m., and 1:00 p.m., revealed the resident lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. During each observation the flow meter on the resident's oxygen concentrator revealed an oxygen flow rate between one-half and one liter per minute. Each observation revealed Resident #62's catheter collection bag was lying on the floor next to the bed.

Review of Resident #62's physician orders revealed in part the following:
"Change catheter Q [every] month and prn [as needed]/when collecting urine specimen with 16 french/10cc [cubic centimeter] coude catheter. Order Date: 3/16/2021."
"O2 [oxygen] @ [at] 2 [two] liters continuously check O2 sats [saturation (1)] Q [every] shift for copd [chronic obstructive pulmonary disease]. Order Date 2/15/2021."

The comprehensive care plan for Resident # 62 dated 04/22/2020 documented, "Focus: Alteration in elimination of bowel and bladder Indwelling Urinary Catheter Date Initiated: 04/22/2020." Under "Interventions" it documented, "Keep drainage bag of catheter below the level of the bladder at all times and off floor. Date Initiated: 04/22/2020."

The comprehensive care plan for Resident # 62 dated 01/11/2017 documented in part, "Focus: Impaired Cardiovascular status related to: Congestive Heart Failure (CHF), Hypertension....Date Initiated: 01/11/2017." Under "Intervention" it documented, "Administer

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Oxygen 2L/NC [two liters by nasal cannula] per MD [medical doctor] order for COPD. Date Initiated: 06/21/2019. Revision on: 03/15/2020."

On 12/01/2021 at approximately 2:37 p.m. an interview with LPN [licensed practical nurse] # 1. After reviewing Resident # 62's comprehensive care plan for an indwelling catheter and the administration of oxygen, LPN # 1 was asked if Resident #62's care plan was being followed based on the observations documented above. LPN # 1 stated, "No." When asked to describe the purpose of a care plan LPN # 1 stated, "So we can meet their specific cares."

On 11/29/2021 at approximately 3:00 p.m., during the entrance conference with ASM [administrative staff member] # 1, interim administrator, they were asked what standard of practice the nursing staff follows. ASM # 1 stated, that they follow Lippincott and provided a copy of the cover of the standard that documented in part, "LIPPINCOTT. Nursing EIGHT EDITION. Copyright @ 2019."

Review of the "LIPPINCOTT. Nursing EIGHT EDITION. Copyright @ 2019" page 130 "Care Plan Preparation" provided by the facility on 12/02/2021 failed to document information regarding the implementation of a resident's care plan.

On 12/01/2021 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the interim administrator, ASM # 2, director of nursing, ASM # 4, director of clinical operations and ASM # 5, regional vice president of operations, were made aware of the findings.

No further information was provided prior to exit.

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References:
[1] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm.

F 657 Care Plan Timing and Revision
SS=D CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to–
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced

F 657 **F657**

1. Resident #3, #31, and #15 remain safely in the center. Resident #3 comprehensive care plan was revised to reflect the restorative program. Resident #31 care plan was revised to include the use of bed rails. Resident #15 care plan was revised to address the administration of an anticoagulant.

2. Current residents in the center have the potential to be affected. These residents were reviewed and no issues noted.

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F 657	Continued From page 77	F 657	3. The DON/designee provided re-education to current licensed nurses and the current IDT team regarding revising a comprehensive care plan when they are on a restorative program, anticoagulant and use bed rails.	

by:
Based on observation, staff interview and facility document review it was determined facility staff failed to review and revise the comprehensive care plan for three of 46 residents in the survey sample, Resident #3, Resident #31 and Resident #15.

1. The facility staff failed to revise the Resident #3's comprehensive care plan to address the resident beginning a restorative program following completion of physical therapy on 3/26/21.

2. The facility staff failed to review and revise Resident #15's comprehensive care plan to address the administration of an anticoagulant prescribed by the physician on 05/27/2021.

3. The facility staff failed to review and revise Resident #31's comprehensive care plan for the use of bed rails.

The findings include:

1. Resident #3 was admitted to the facility on 7/25/18 with diagnosis that included but were not limited to: multiple sclerosis (progressive disease in which the nerve fibers of the brain and spinal cord lose their myelin cover) (1), scoliosis (abnormal lateral or sideward curve to the spine) (2) dementia (progressive state of mental decline, including memory function and judgement) (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/17/21, coded Resident #3 as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score,

4. Residents comprehensive care plan will be reviewed 5x a week for 1 month to ensure that care plans are revised for residents with new orders for restorative program, anticoagulants and bed rails. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.

5. Compliance Date: 01/04/22

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indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded Resident #3 as requiring extensive assistance for bed mobility, transfer, locomotion, dressing, hygiene; dependent for bathing and supervision for eating. Walking did not occur.

A review of the physical therapy notes documented in part, "Treatment began 3/6/21 ended 3/26/21. Discharge Plans: to remain in the same skilled nursing facility with reduced burden on caregivers and continue RNP (restorative nursing program).

A review of the facility "Restorative Program" form, which was not dated, documented the following: Restorative Program: Active ROM (range of motion) and ambulation. Precaution: gait belt and monitor exertion.

A review of the orders failed to evidence orders for restorative program for Resident #13 beginning March 2021.

A review of the comprehensive care plan initiated on 7/26/18 with revision 11/24/21, documented in part, "FOCUS: At risk for falls related to multiple sclerosis. Interventions: Restorative programs and Therapy referral- dated 7/26/18 with revision 11/7/18. The comprehensive care plan failed to evidence a revision to address include a restorative program for Resident #13 beginning after the 3/26/21, completion of physical therapy.

An interview was conducted on 12/1/21 at 1:55 PM with ASM (administrative staff person) #2, the director of nursing. When asked about the purpose of the comprehensive care plan, ASM #2

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stated, "The care plan is to provide the framework and goals of care for the resident." When asked who is responsible for reviewing and revising the care plan, ASM #2 stated, "The care plan is updated by the MDS person after our meeting on Mondays."

An interview was conducted on 12/1/21 at 2:10 PM with RN (registered nurse) #1, the MDS Coordinator. When asked, who is responsible to review and revise the care plan, RN #1 stated, "Interdisciplinary team, MDS coordinator and nursing, nursing is ultimately responsible. Both to develop and review/revise the care plan."

An interview was conducted on 12/2/21 at 8:30 AM with LPN (licensed practical nurse) #1. When asked who is responsible to review and revise the care plan, LPN #1 stated, "All nursing, the MDS coordinator, social services and the IDT." LPN #1 stated, "Revisions are usually made when there is a change in the resident's condition, goals or treatment.

On 12/1/21 at 5:00 PM, ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were informed of the findings.

A review of the facility's policy "Care Plan Preparation", which documented in part, "A care plan directs the patient's nursing care from admission to discharge. A nursing care plan serves as a database for planning assignments, giving change-of-shift reports, conferring with the practitioner or other members of the health care team, planning patient discharge and

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documenting patient care."

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 378.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 519.
(3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154.

2. Resident #15 was admitted to the facility on 9/14/18, and most recently readmitted on 10/12/20, with diagnoses including chronic obstructive lung disease, heart disease, and chronic blood clots. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/7/21, Resident #15 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status).

A review of Resident #15's clinical record revealed the following physician's order: "Eliquis [Apixaban (1)] Tablet 5 MG (milligrams) Give 5 mg by mouth two times a day for DVT (deep vein blood clot). Monitor for s/s [signs and symptoms] of bleeding/bruising...Order Date 05/27/2021 10:06 a.m."

A review of Resident #15's MARs (medication administration records) for September, October, and November 2021 revealed the resident

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received the Eliquis as ordered.

A review of Resident #15's comprehensive care plan, dated 9/20/18, with an updated date of 3/19/21, failed to reveal information regarding Resident #15 receiving the anticoagulant Eliquis.

On 11/30/21 at 3:34 pm, RN (registered nurse) #1, the MDS coordinator, was interviewed. She stated she is responsible for developing the care plan for medications which residents are receiving. RN #1 stated the purpose of the care plan is to individualize resident care, and to make sure the staff know exactly what the residents need to best meet their needs. When asked about Resident #15's care plan for anticoagulants, RN #1 stated she would need to check.

On 11/30/21 at 4:45 p.m., RN #1 stated she had checked Resident #15's care plan, and did not find any information related to the Eliquis. RN #1 stated, "I will add it. It should have been on there." RN #1 stated she must have "just missed it," as her usual process is to develop a care plan for any anticoagulants a resident is receiving.

An interview was conducted on 12/1/21 at 1:55 p.m. with ASM (administrative staff person) #2, the director of nursing. When asked the purpose of the comprehensive care plan, ASM #2 stated, "The care plan is to provide the framework and goals of care for the resident." When asked who is responsible for reviewing and revising the care plan, ASM #2 stated, "The care plan is updated by the MDS person after our meeting on Mondays."

An interview was conducted on 12/1/21 at 2:10

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p.m. with RN (registered nurse) #1, the MDS Coordinator. When asked the purpose of the comprehensive care plan, RN #1 stated, "It is to provide goals and interventions of care based on resident's needs." When asked who is responsible for the review and revision of the comprehensive care plan, RN #1 stated, "Interdisciplinary team (IDT), MDS coordinator and nursing, nursing is ultimately responsible. Both to develop and review, revise the care plan."

An interview was conducted on 12/2/21 at 8:30 a.m. with LPN (licensed practical nurse) #1. When asked who is responsible to review and revise the care plan, LPN #1 stated, "All nursing, the MDS coordinator, social services and the IDT." LPN #1 stated, "Revisions are usually made when there is a change in the resident's condition, goals or treatment."

On 12/1/21 at 4:50 p.m., ASM (administrative staff member) #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical operations, and ASM #5, the regional vice president of operations, were informed of these concerns.

No further information was provided prior to exit.

REFERENCES
(1)"Apixaban is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. Apixaban is also used to prevent deep vein thrombosis (DVT; a blood clot, usually in the leg) and pulmonary embolism (PE; a blood clot in the lung) in people who are having

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hip replacement or knee replacement surgery. Apixaban is also used to treat DVT and PE and may be continued to prevent DVT and PE from happening again after the initial treatment is completed. Apixaban is in a class of medications called factor Xa inhibitors. It works by blocking the action of a certain natural substance that helps blood clots to form." This information was taken from the website https://medlineplus.gov/druginfo/meds/a613032.html.

3. Resident #31 was admitted to the facility on 4/16/20. Resident #31's diagnoses included but were not limited to muscle weakness, high blood pressure and seizures. Resident #31's quarterly minimum data set assessment with an assessment reference date of 10/4/21, coded the resident as being cognitively intact.

Review of Resident #31's clinical record revealed a physician's order dated 4/22/21 for halos (bed rails) to bilateral sides of the bed to aid in repositioning and turning.

Review of Resident #31's comprehensive care plan dated 4/23/20 failed to reveal documentation regarding bed rails.

On 12/1/21 at 2:07 p.m., an interview was conducted with RN (registered nurse) #1 (the minimum data set coordinator). RN #1 stated the purpose of the care plan is to come up with the plan of care for that patient during their time in the facility so that everyone including the patient is aware of what the goals are. RN #1 stated the reviewing and revising of care plans is shared by the interdisciplinary team but the nurses are ultimately responsible. RN #1 stated the care plan should be reviewed and revised for the use

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of bed rails because the use of bed rails is a part of the resident's day to day care.

On 12/1/21 at 4:56 p.m., ASM (administrative staff member) #1 (the interim administrator), ASM #2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 (the regional vice president of operations) were made aware of the above concern.

No further information was presented prior to exit.

F 684 Quality of Care
SS=D CFR(s): 483.25

§ 483.25 Quality of care
Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, facility document review and staff interview it was determined that the facility staff failed to ensure treatment and care in accordance with professional standards of practice, and the comprehensive plan of care for one of 46 residents in the survey sample, Resident # 201.

The facility staff failed to administer Gabapentin to Resident #201 on 05/22/2021, according to the physician's orders.

The findings include:

F 684 **F684**

1. Resident #201 is no longer in the center.

2. Current residents have the potential to be affected.

3. The DON/designee provided re-education to current licensed nurses on how to obtain medications from the STAT box.

4. 5x per week new admissions MAR's will be reviewed to ensure medications were available or were pulled from the STAT box as appropriate. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.

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Resident # 210 was admitted to the facility with diagnoses that included but were not limited to: breast cancer, pain, diabetes mellitus [2] and kidney disease, high blood pressure.

Resident # 201's MDS (minimum data set), an admission 5-day assessment with an ARD (assessment reference date) of 05/24/2021 coded Resident # 201 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

Review of Resident #201's clinical record revealed a physician's order dated 5/21/21 and signed by the physician on 5/24/21 documented in part: Gabapentin Capsule. Give 300 mg (milligram) by mouth two times a day for neuropathy."

Review of Resident #201's eMAR [electronic medication administration record] dated May 2021 documented the physician's orders as stated above from 05/21/2021 through 05/24/2021. The eMAR further documented the code "3 [three] = Hold/See Nurse's Notes" for the Gabapentin on 05/22/2021 at 9:00 a.m.

The nurse's "Progress Notes" dated 05/22/2021 for Resident # 201 documented, "Gabapentin Capsule. Give 300 mg by mouth two times a day for neuropathy. Pharm [pharmacy] sent wrong dose."

The facility's STAT [immediate]-drug box inventory list documented in part, "Gabapentin 100mg Tablet. Qty [quantity] 10."

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On 12/01/2021 at 8:18 a.m., a request to interview the nurse who admitted resident # 201 was made to ASM [administrative staff member] # 1, interim administrator. ASM # 1 stated that the nurse was no longer employed by the facility.

On 12/01/2021 at approximately 10:05 a.m., an interview was conducted with ASM # 2, director of nursing. ASM #2 was asked to describe the procedure the nursing staff follows to obtain medications for newly admitted residents. ASM # 2 stated, "Before they arrive, we get a report from the hospital or they arrive with a discharge summary with their medications. The admitting nurse calls the nurse practitioner [NP] or the physician to go over the resident's medications and make any necessary changes and then they give a verbal order for the medications. The order is then faxed to the pharmacy if there is a narcotic, the nurse gets a written order. If the resident is a late day admission the medications arrive the next morning, if the admission is early in the day, the medication arrives by the end of the day." When asked about the procedure staff follows when a resident's medications are not available, ASM # 2 stated, "They [nurse] checks the STAT-drug box [prepared by the pharmacy to provide for initiating therapy prior to the receipt of ordered drug from the pharmacy] and the house stock of medications. If they are not in the STAT-drug box or in the house stock, the nurse should call the pharmacy, notify the NP or physician, and let the resident and/or responsible party know." After reviewing Resident # 201's eMAR dated May 2021, nurse's progress notes dated 05/22/2021, the STAT-drug box list and the facility's house stock list, ASM # 2 was asked if the facility STAT-drug box contained the appropriate dosage of gabapentin that could have

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been administered to Resident # 201 on 05/22/2021. ASM # 2 stated yes.

The facility policy for medication administration failed to document instructions for obtaining medications from the STAT-drug box.

On 12/01/2021 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the interim administrator, ASM # 2, director of nursing, ASM # 4, director of clinical operations and ASM # 5, regional vice president of operations, were made aware of the findings.

No further information was provided prior to exit.

Complaint deficiency

References:
[1] Used to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia (PHN; the burning, stabbing pain or aches that may last for months or years after an attack of shingles). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html.

[2] A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

F 688 SS=D Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)

F 688 **F688**

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F 688	Continued From page 88 §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 observation, resident interview staff interview and facility document review it was determined that the facility staff failed to provide treatment and services to maintain or improve mobility for one of 46 residents in the survey sample, Resident #3. The facility staff failed to implement a RNP (restorative nursing program) for Resident #3 following completion of physical therapy 3/26/21. The findings include: Resident #3 was admitted to the facility on 7/25/18 with diagnosis that included but were not limited to: multiple sclerosis (progressive disease in which the nerve fibers of the brain and spinal cord lose their myelin cover) (1), scoliosis	F 688	1. Resident #3 remains safely in the center. Referral was made to therapy to evaluate. 2. Current residents in the center that have limited mobility have the potential to be affected. These residents were reviewed and no concerns noted. 3. The DON/designee provided re-education to the therapy provider to give new referrals for restorative nursing program to DON so they can be implemented timely for the residents as appropriate. 4. Once a week restorative referrals will be reviewed to ensure services were implemented timely. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date 01/04/22	

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(abnormal lateral or sideward curve to the spine) (2) dementia (progressive state of mental decline, including memory function and judgement) (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/17/21, coded Resident #3 as scoring a 14 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded Resident #3 as requiring extensive assistance for bed mobility, transfer, locomotion, dressing, hygiene; dependent for bathing and supervision for eating. Walking did not occur.

An interview was conducted on 11/29/21 at 5:15 PM with Resident #3. When asked if she was receiving therapy services, Resident #3 stated, "I have multiple sclerosis. I finished physical therapy many months ago and was supposed to start another program."

A review of the physical therapy notes documented in part, "Treatment began 3/6/21 ended 3/26/21. Discharge Plans: to remain in the same skilled nursing facility with reduced burden on caregivers and continue RNP (restorative nursing program).

A review of the facility "Restorative Program" form, which was not dated, documented the following: Restorative Program: Active ROM (range of motion) and ambulation. Precaution: gait belt and monitor exertion.

A review of the physician's orders failed to evidence orders for restorative program for Resident #13 beginning March 2021.

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A review of Resident #3's comprehensive care plan initiated on 7/26/18 with revision 11/24/21, documented in part, "FOCUS: At risk for falls related to multiple sclerosis. Interventions: Restorative programs and Therapy referral- dated 7/26/18 with revision 11/7/18. The comprehensive care plan failed to evidence a revision to address include a restorative program for Resident #13 beginning after the 3/26/21, completion of physical therapy.

An interview was conducted on 11/30/21 at 3:50 PM with OSM (other staff member) #1, the physical therapist. When asked if services were being provided for Resident #3, OSM #1 stated, "No, we finished therapy with her in March 2021 and she was transitioned to RNP." When asked who provides RNP, OSM #1 stated, "Nursing provides those services." When asked why there was not an order for the RNP, OSM #1 stated, "I don't know why, we give nursing the papers for RNP and they put in the order." OSM #1 stated I didn't know she wasn't receiving restorative.

An interview was conducted on 11/30/21 at 4:30 PM with Resident #3. When asked if she was receiving restorative nursing services, Resident #3 stated, "No, there is no restorative program and I do not know why. I have tried to find out but cannot get an answer."

An interview was conducted on 12/1/21 at 8:37 AM with CNA (certified nursing assistant) #1, the restorative aide. CNA #1 was asked about the process staff follows for a resident to be placed into the RNP. CNA #1 stated, "The resident goes to therapy and then therapy fills out restorative papers with one copy to myself and the other

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restorative aide and the second copy goes to the restorative nurse who puts the order into the computer. We cannot do restorative nursing if we do not have orders. I believe we have the restorative paper for Resident #3, and will bring to you. We have not had a nurse in charge of the restorative program for several months." When asked if they had, a nurse in charge of the program back in March or April 2021, CNA #1 stated, "I don't believe so, but I can't be certain. If she (Resident #3) hasn't received the services, I guess we didn't."

An interview was conducted on 12/1/21 at 9:05 AM with ASM (administrative staff member) #1, the interim administrator. ASM #1 provided the restorative order form for Resident #3. When asked about the form, ASM #1 stated, "Yes, this is the order for restorative care for Resident #3. Yes, I do not know the date but that is the most recent paper from PT." ASM #1 stated, "I do not know what the process is for entering the order into the EMR (electronic medical record) if there is not a restorative nurse here. I will find out." ASM #1 was asked about the last time the restorative nurse position was filled. ASM #1 stated, "I'm not sure and I don't know the process, but I will find out." When informed staff had stated the position was vacant in March or April, ASM #1 stated, "That is possible."

An interview was conducted on 12/1/21 at 9:43 AM with OSM #2, physical therapist. When shown the order for restorative care form for Resident #3, OSM #2 stated, "Yes, this is the form we fill out when the resident is finished with PT (physical therapy), when they are completed with their skilled therapy, so the RNP can carry on their function and it is the plan to follow."

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An interview was conducted on 12/1/21 at 11:15 AM with ASM #2, the director of nursing. When asked about the process for the RNP, ASM #2 stated, "I was hired 6/22/21. If I were to be honest with you, we have restorative aides and we have not had a restorative nurse in this year. There has not been anyone in nursing in charge of the program. We just have not had staff to fill that position and there is not any designated back up. I don't know if Resident #3 is getting the care."

On 12/1/21 at 5:00 PM, ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were informed of the findings.

A review of the facility's "Restorative Nursing Program" manual dated 2017, documents in part, "The restorative nursing program is developed to serve as a guide in establishing individualized restorative care to assist each resident in achieving the highest level of self-care and independence possible. Restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. Restorative nursing is indicated when the resident displays potential for functional decline following the end of therapy or has achievable goals for functional improvement through restorative care. Restorative nursing is essential for carryover of therapeutic teaching. Implementation of restorative interventions is provided by Certified Nursing Assistants, under the supervision of a licensed nurse."

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F 688	Continued From page 93 No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 378. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 519. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690	**F690** 1. Resident #62 remains safely in the center. The catheter collection bag was removed from the floor on the day of survey. 2. Current residents in the center that have catheters have the potential to be affected. These residents were reviewed and no concerns noted. 3. The DON/designee provided re-education to the licensed nurses and CNA's regarding the proper placement of catheter collection bags.	

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F 690	Continued From page 94	F 690	4. Weekly audits will be competed for 1 month on residents with catheters collection bags to ensure they are not on the floor. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date: 01/04/22	

(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, it was determined that facility staff failed to ensure care and services for an indwelling catheter to prevent infection for one of 46 residents in the survey sample, Residents # 62.

The facility staff failed to keep Resident # 62's catheter collection bag off the floor.

The findings include:

Resident # 62 was admitted to the facility with diagnoses that included but were not limited to: obstructive uropathy [1]. Resident # 62's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/02/2021, coded Resident # 62 as scoring a 9 [nine] on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 - being moderately impaired of cognition for making daily decisions. Section H "Bladder and Bowel" coded Resident # 62 as having an indwelling catheter.

On 11/30/21 at approximately 8:45 a.m., an

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observation of Resident # 62's catheter collection bag revealed it was lying on the floor next to the bed.

On 11/30/21 at approximately 10:17 a.m., an observation of Resident # 62's catheter collection bag revealed it was lying on the floor next to the bed.

On 11/30/21 at approximately 1:00 p.m., an observation of Resident # 62's catheter collection bag revealed it was lying on the floor next to the bed.

The physician's order for Resident # 62 documented, "Change catheter Q [every] month and prn [as needed]/when collecting urine specimen with 16 french/10cc [cubic centimeter] coude catheter. Order Date: 3/16/2021."

The comprehensive care plan for Resident # 62 dated 04/22/2020 documented, "Focus: Alteration in elimination of bowel and bladder Indwelling Urinary Catheter Date Initiated: 04/22/2020." Under "Interventions" it documented, "Keep drainage bag of catheter below the level of the bladder at all times and off floor. Date Initiated: 04/22/2020."

On 11/30/2021 at approximately 2:37 p.m. an interview and observation of Resident # 62's catheter collection bag was conducted with LPN [licensed practical nurse] # 7. Upon entering Resident # 62's room, LPN # 7 was asked to observe and describe where Resident # 62's catheter collection bag was located. LPN # 7 stated that it was lying on the floor next to the bed. LPN # 7 further stated that the collection bag should be hanging on the side of the bed off

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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the floor. When asked why it was important to keep the catheter collection bag off the floor, LPN # 7 stated, "To prevent infection."

On 11/29/2021 at approximately 3:00 p.m., during the entrance conference with ASM [administrative staff member] # 1, interim administrator, they were asked what standard of practice the nursing staff follow. ASM # 1 stated, that they follow Lippincott and provided a copy of the cover of the standard that documented in part, "LIPPINCOTT. Nursing EIGHT EDITION. Copyright @ 2019."

According "LIPPINCOTT. Nursing EIGHT EDITION. Copyright @ 2019" documented in part. "Nursing Alert: Don't place the drainage bag on the floor to reduce the risk of contamination ... p387."

On 12/01/2021 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the interim administrator, ASM # 2, director of nursing, ASM # 4, director of clinical operations and ASM # 5, regional vice president of operations, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] A condition in which the flow of urine is blocked. This causes the urine to back up and injure one or both kidneys. This information was obtained from the website: https://medlineplus.gov/ency/article/000507.htm

F 695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)

§ 483.25(i) Respiratory care, including

F 695 **F695**

1. Resident #62 remains safely in the center. Resident

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tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide respiratory services according to the physician's orders one of 46 residents in the survey sample, Residents # 62.

The facility staff failed to administer Resident # 62's oxygen at two liters per minute according to the physician's orders.

The findings include:

Resident # 62 was admitted to the facility with diagnoses that included but were not limited to: respiratory failure [1] and chronic obstructive pulmonary disease [2]. Resident # 62's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/02/2021, coded Resident # 62 as scoring a 9 [nine] on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 15 for "Oxygen Therapy" while a resident.

On 11/30/21 at approximately 8:45 a.m., an

F 695 treatment orders for oxygen were reviewed and no further issues were identified.

2. Current residents in the center that have oxygen prescribed have the potential to be affected. These residents were reviewed and no concerns noted.

3. The DON/designee provided re-education to the licensed nurses regarding following physician orders related to oxygen use.

4. Weekly audits will be competed for 1 month on residents with prescribed oxygen to ensure they are receiving as prescribed. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately.

5. Compliance Date: 01/04/22

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observation of Resident # 62 revealed the resident lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on oxygen Resident #62's oxygen concentrator revealed an oxygen flow rate between one-half and one liter per minute.

On 11/30/21 at approximately 10:17 a.m., an observation of Resident # 62 revealed the resident lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on oxygen Resident #62's oxygen concentrator revealed an oxygen flow rate between one-half and one liter per minute.

On 11/30/21 at approximately 1:00 p.m., an observation of Resident # 62 revealed the resident lying in bed receiving oxygen by nasal cannula connected to an oxygen concentrator. Observation of the flow meter on oxygen Resident #62's oxygen concentrator revealed an oxygen flow rate between one-half and one liter per minute.

The physician order for Resident # 62 documented "O2 [oxygen] @ [at] 2 [two] liters continuously check O2 sats [saturation] Q [every] shift for copd [chronic obstructive pulmonary disease]. Order Date: 2/15/2021."

The comprehensive care plan for Resident # 62 dated 01/11/2017 documented in part, "Focus: Impaired Cardiovascular status related to: Congestive Heart Failure (CHF), Hypertension....Date Initiated: 01/11/2017." Under "Intervention" it documented, "Administer Oxygen 2L/NC [two liters by nasal cannula] per

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MD [medical doctor] order for COPD. Date Initiated: 06/21/2019. Revision on: 03/15/2020."

On 11/30/2021 at approximately 2:37 p.m. an interview and observation of Resident # 62's oxygen concentrator flow meter was conducted with LPN [licensed practical nurse] # 7. Upon entering Resident # 62's room, LPN # 7 was asked to read the flow meter on Resident # 62's oxygen concentrator. LPN # 7 stated that the flow meter read one liter per minute. When asked what the oxygen flow rate should be for Resident # 62, LPN # 7 stated they would need to check the physician's order. After LPN #7 looked up the physician's order for Resident # 62's oxygen flow rate, LPN # 7 stated, "It is two liters per minute." When asked why it was important for a resident to receive the correct amount of oxygen, LPN # 7 stated, "A low rate could cause hypoxia [3]."

On 12/01/2021 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the interim administrator, ASM # 2, director of nursing, ASM # 4, director of clinical operations and ASM # 5, regional vice president of operations, were made aware of the findings.

No further information was provided prior to exit.

References:
[1] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

[2 Disease that makes it difficult to breath that can lead to shortness of breath. This information

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F 695	Continued From page 100 was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. [3] Hypoxia: a state in which oxygen is not available in sufficient amounts at the tissue level to maintain adequate homeostasis; this can result from inadequate oxygen delivery to the tissues either due to low blood supply or low oxygen content in the blood (hypoxemia). This information was obtained from the website: https://pubmed.ncbi.nlm.nih.gov/29493941/	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to complete an annual CNA (certified nursing aide) performance review for two of five CNA record reviews, CNA #6 and CNA #7. The facility staff failed to complete an annual performance review for CNA #6, hired on 8/29/19 and CNA #7, hired on 1/7/20. The findings include: CNA #6 was hired on 8/29/19. Review of CNA #6's record revealed a performance review with no date.	F 730	**F730** 1. CNA #6 and CNA #7 remain employed at the center. Performance reviews were completed and delivered. 2. Current CNAs in the center have the potential to be affected. Current CNAs were reviewed and any concerns were addressed. 3. The Administrator provided re-education to DON and HR Director regarding the requirement to complete annual CNA reviews and provide education based on these reviews.	

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F 730	Continued From page 101 CNA #7 was hired on 4/2/18. Review of CNA #7's record revealed the last performance review was completed on 1/7/20. On 12/1/21 at 4:56 p.m., an interview was conducted with ASM (administrative staff member) #5 (the regional vice president of operations). ASM #5 stated CNA performance reviews should be completed by the CNA's supervisor annually. At this time, ASM #1 (the interim administrator), ASM #2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 were made aware of the above concern. The facility policy titled, "Performance Evaluations" documented, "2. A performance evaluation must be completed on each employee within 30 days of their original service date utilizing the Annual Performance Review Forms-employee and management..." No further information was presented prior to exit.	F 730	4. Monthly audit will be completed to ensure annual CNA reviews are compliant. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5. Compliance Date: 01/04/2022	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		

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that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview it was determined that the facility staff failed to provide pharmacy services for one of 46 residents in the survey sample, Resident # 201.

The facility staff failed to ensure the medications, Metoprolol [1] Zestoretic [2], Glimepiride [3] and Ozempic [4] were available for administration to Resident # 201 as ordered by the physician on 5/22/21, 5/23/21 and 5/24/21.

The findings include:

Resident # 210 was admitted to the facility with diagnoses that included but were not limited to: breast cancer, pain, diabetes mellitus [5] and kidney disease, high blood pressure.

1. Resident #201 no longer resides in the center.
2. Current residents on metoprolol, zestoretic, glimepiride and ozempic in the center have the potential to be affected. Residents reviewed and no concerns noted.

3. The DON/designee will re-educate licensed nurses on obtaining medications as ordered from the pharmacy.

4. A report will be generated of metoprolol, zestoretic, glimepiride and ozempic medications to ensure they were available for administration 5 times a week. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately.

5. Compliance Date: 01/04/22

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Resident # 201's MDS (minimum data set), an admission 5-day assessment with an ARD (assessment reference date) of 05/24/2021 coded Resident # 201 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

Review of Resident #201's clinical record revealed a physician's order dated 5/21/21, signed by the physician on 5/24/21, that documented in part: Metoprolol ER [extended release] 25mg [milligrams]. Give 1 [one] tablet by mouth one time a day for htn [hypertension - high blood pressure]; Zestoretic 20-25 mg. Give 1 [one] tablet by mouth one time a day for htn [hypertension - high blood pressure]; Glimepiride Tablet. Give 2mg by mouth two times a day for DM [diabetes mellitus]; Ozempic [5] (0.25 or 0.5 MG/DOSE) Solution Pen-Injector 2 MG/1.5ML [milliliter]. Inject 0.5 mg subcutaneously [beneath the skin] one time a day every Sun [Sunday] for dm."

Review of the Resident #201's eMAR [electronic medication administration record] dated May 2021, documented the physician's orders as stated above from 05/21/2021 through 05/24/2021. The eMAR further documented the code "3 [three] = Hold/See Nurse's Notes" for metoprolol on 5/22/2021 and 05/23/2021 at 9:00 a.m.; ozempic on 05/23/2021 at 9:00 a.m.; zestoretic on 05/22/2021 and 05/23/2021 at 9:00 a.m.; glimepiride 5/22/2021 and 05/23/2021 at 9:00 a.m. and coded "7 [seven] = See Nurse's Notes" on 05/24/2021 at 9:00 a.m.

The nurse's "Progress Notes" dated 05/22/2021

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and 05/23/2021 for Resident # 201 documented, "Gabapentin Capsule. Give 300 mg by mouth two times a day for neuropathy.
Pharm [pharmacy] sent wrong dose; Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG. Give 1 tablet by mouth one time a day for htn. awaiting delivery; Glimepiride Tablet. Give 2 mg by mouth two times a day for DM. awaiting delivery."

The nurse's "Progress Notes" dated 05/23/2021" Ozempic (0.25 or 0.5 MG/DOSE) Solution Pen-injector 2 MG/1.5ML. Inject 0.5 mg subcutaneously one time a day every Sun for dm. awaiting delivery."

The facility's STAT [immediate]-drug box inventory list was reviewed. The STAT-drug box failed to evidence the medications metoprolol, zestoretic, glimepiride and ozempic.

On 12/01/2021 at 8:18 a.m., a request to interview the nurse who admitted resident # 201 was made to ASM [administrative staff member] # 1, interim administrator. ASM # 1 stated that the nurse was no longer employed by the facility.

On 12/01/2021 at approximately 10:05 a.m., an interview was conducted with ASM # 2, director of nursing. When asked to describe the procedure the nursing staff follows to obtain medications for newly admitted residents, ASM # 2 stated, "Before they arrive, we get a report from the hospital or they arrive with a discharge summary with their medications. The admitting nurse calls the nurse practitioner [NP] or the physician to go over the resident's medications and make any necessary changes and then they give a verbal order for the medications. The

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order is then faxed to the pharmacy If there is a narcotic, the nurse gets a written order. If the resident is a late day admission the medications arrive the next morning, if the admission is early in the day, the medication arrive by the end of the day." When asked about the procedure staff follows when a resident's medications are not available, ASM # 2 stated, "They [nurse] checks the STAT-drug box [prepared by the pharmacy to provide for initiating therapy prior to the receipt of ordered drug from the pharmacy] and the house stock of medications. If they are not in the STAT-drug box or in the house stock, the nurse should call the pharmacy, notify the NP or physician, and let the resident and/or responsible party know." After reviewing Resident # 201's eMAR dated May 2021, nurse's progress notes dated 05/21/2021 through 05/24/2021, and the STAT-drug box list, ASM # 2 was asked if the STAT-drug box contained the above medications for Resident # 201's medications. ASM # 2 stated no.

The facility pharmacy policy titled, "Medication Management" failed to specifically document steps to take if a medication is not available and not in the STAT box.

On 12/01/2021 at approximately 4:10 p.m., ASM [administrative staff member] # 1, the interim administrator, ASM # 2, director of nursing, ASM # 4, director of clinical operations and ASM # 5, regional vice president of operations, were made aware of the findings.

No further information was provided prior to exit.

Complaint deficiency

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References:

[1] Used alone or in combination with other medications to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682864.html.

[2] The combination of lisinopril and hydrochlorothiazide is used to treat high blood pressure. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601070.html.

[3] Used along with diet and exercise, and sometimes with other medications, to treat type 2 diabetes (condition in which the body does not use insulin normally and, therefore, cannot control the amount of sugar in the blood). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a696016.html.

[4] Used along with a diet and exercise program to control blood sugar levels in adults with type 2 diabetes (condition in which the body does not use insulin normally and therefore cannot control the amount of sugar in the blood) when other medications did not control the sugar levels well enough. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a618008.html.

[5] A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/

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001214.htm.

F 761 Label/Store Drugs and Biologicals
SS=E CFR(s): 483.45(g)(h)(1)(2)

§483.45(g) Labeling of Drugs and Biologicals
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review it was determined that the facility staff failed to ensure medications were labeled and stored in a secure manner in two of four medication carts, (South Wing medication cart-one and South Wing medication cart-three).

F 755

F 761 **F761**

1. South Wing Cart One and Three have medications labeled and stored in a secure manner.

2. Medication carts in the facility were audited to ensure medications were labeled and stored in a secure manner.

3. The DON/designee will re-educate licensed nurses on medication labeling and storage.

4. An audit will be completed weekly for 1 month to ensure that medications are labeled and stored in a secure manner. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately.

5. Compliance Date: 01/04/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE HILL HEALTH AND REHAB	110 CHALMERS COURT BERRYVILLE, VA 22611

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 108	F 761		

Observation of the South wing medication cart-one revealed two half-loose unidentified pills in drawer one, three whole-loose unidentified pills in drawer three and one whole-loose unidentified pill in drawer four of the medication cart. Observation of the South wing-cart three revealed, one whole-loose unidentified pill in drawer two, two half and one-loose unidentified pills in drawer three of the medication cart.

The findings include:

On 11/29/21 at approximately 5:35 PM, an observation of South wing-medication cart-one was conducted with LPN (licensed practical nurse) #5. Observation inside the drawers of South wing-medication cart-one revealed the following:
-Drawer one: two half-loose unidentified pills.
-Drawer two: three whole-loose unidentified pills.
-Drawer four: one whole-loose unidentified pill.

On 11/29/21 at approximately 5:55 PM, an observation of South wing medication cart three was conducted with LPN #4. Observation inside the drawers of South wing-medication cart-three revealed the following:
-Drawer two: one whole-loose unidentified pills.
-Drawer three: two half and one whole-loose unidentified pills.

The loose pills in each drawer above were observed located behind the medication cards stored in each drawer.

An interview was conducted on 11/29/21 at 5:35 PM with LPN #5. When asked about the loose medications in the medication cart drawers, LPN #5 stated, "I need to throw those pills away. I

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don't know what the pills are, so we cannot use them because they are out of the packaging."

An interview was conducted on 11/29/21 at 5:55 PM with LPN #4. When asked about the loose pills in the medication cart drawers, LPN #4 stated, "No, they should not be in the drawers loose like that. You do not know what the pill is and you have to dispose of them. If I knew they were in the drawers like that, I would have thrown them out."

On 11/29/21 at 5:40 PM, ASM (administrative staff member) #1, the interim administrator provided us with the title page to Lippincott Nursing Procedures, 8th Edition.

On 12/1/21 at 5:00 PM, ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #3, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were informed of the findings.

According to the facility's "Medication Storage" policy, dated September 2010, documents in part, "Medications and biologicals are stored properly, following manufacturers or pharmacy provider recommendations to maintain their integrity and to support safe, effective drug administration. Outdated, contaminated, discontinued or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal."

No further information was provided prior to exit.

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812	**F812**	

§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 facility document review it was determined that the facility staff failed to store food in two of two nourishment rooms in accordance with professional standards for food service safety.

The findings include:

A. The facility failed to properly label and date resident food items on the North unit nourishment room.

On 11/30/2021 at 8:45 a.m., an observation was conducted of the nourishment room on the north unit. Observation of the refrigerator revealed a salad in a plastic container with no date or name,

1. The south and north nourishment rooms have food stored in accordance with professional standards for food service safety.

2. An audit of current nourishment rooms were completed to ensure food was stored in accordance with professional standards for food safety.

3. The Administrator/designee will re-educate dining services proper food storage.

4. A bi- weekly audit of the nourishment rooms will be completed for 2 month to ensure food storage compliance. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately.

5. Compliance Date: 01/04/22

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a 31 ounce container of spinach artichoke parmesan dip without a name or date, a container of an unidentified green paste without a name or date, two plastic food containers undated without names and a foil packet with the contents not visible and no date or name on them. Further observation revealed a pitcher of an orange colored liquid approximately 1/4 full without a cover, label identifying the contents or a date. Observation of the freezer revealed one ham and cheddar hot pocket without a name or date and a frozen meal out of it's box without a label or date.

On 11/30/2021 at 9:00 a.m., an interview was conducted with OSM (other staff member) #4, interim dietary manager. OSM #4 stated that they had been at the facility for about a week covering and were not sure who was responsible for maintaining the nourishment rooms on the units. OSM #4 stated that there were no current dietary staff who knew the process and they did not know if dietary or nursing was responsible for this.

On 11/30/2021 at 9:10 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that dietary was responsible for checking the nourishment rooms daily and for throwing away anything that was not labeled or dated or expired. LPN #8 stated that nursing was responsible for dating and labeling anything that they received from residents and put in the nourishment room. LPN #8 observed the food items in the refrigerator and freezer of the North unit nourishment room and stated that they should all be thrown away because they were not labeled or dated and they could not identify how old they were or who they belonged to. LPN #8 stated that the orange liquid in the pitcher should be dated, labeled and covered and everything

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would be thrown away.

B. The facility staff failed to dispose of expired food items in the South unit nourishment room.

On 11/30/2021 at 4:20 p.m., an observation was conducted of the nourishment room on the south unit. Observation revealed one half pint of 2% milk with an expiration date of 11/28/21 on the carton and a 46 ounce container of thickened lemon flavored water dated 10/22/2021.

On 11/30/2021 at 4:25 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 observed the one half pint of 2% milk with the date 11/28/21 and the carton of thickened lemon water dated 10/22/2021 and stated, "Yes, they should have been thrown out because they are expired per the dates. I'll throw them out now."

On 12/1/2021 at approximately 5:30 p.m., a request was made to ASM (administrative staff member) #1, the interim administrator for the facility policy on maintaining the nourishment rooms in the facility.

The facility policy "Basic Food Storage" documented in part, "...4. Discard foods that have exceeded their expiration date..."

The facility policy "Use and Storage of Foods Brought to Residents by Family and Visitors" dated 10/2017 documented in part, "...Food item(s) will be labeled with the resident's name, content, the date it was prepared, if known, and a discard/use by date..."

On 12/1/2021 at approximately 5:10 p.m., ASM

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F 812	Continued From page 113 #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were made aware of the findings. No further information was provided prior to exit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care	F 842	**F842** 1. Resident #29 remains safely in the center. 2. Current residents in the center that have an order for treatments have the potential to be affected. 3. The DON/designee will re-educate licensed nurses on completing documentation on the eTAR. 4. 5 times a week, a report will be reviewed for proper documentation in eTAR. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately. 5. Compliance Date: 01/04/22	

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operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review and facility staff interview it was determined that the

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facility staff failed to maintain a complete and accurate record for one of 46 residents in the survey sample, Resident #29.

The findings include:

Resident #29 was admitted to the facility with diagnoses that included but were not limited to sepsis (1) and gastrostomy (2). Resident #29's most recent MDS, a quarterly assessment with an ARD of 9/3/2021, coded Resident #29 as being moderately impaired for making daily decisions. Section M documented Resident #29 having one stage III pressure ulcer (3) on admission and three stage IV pressure ulcers, one being present on admission.

The eTAR (electronic treatment administration record) for Resident #29 dated 10/1/2021-10/31/2021 failed to evidence documentation of the following treatments completed on the following dates,
- On 10/14/2021 and 10/21/2021- "Night, Cleanse around g-tube (gastrostomy tube) site with wound cleanser pat dry apply zinc oxide around g-tube site and cover with dressing QD (every day), every night shift for wound prevention. Order Date 04/23/2021."
- On 10/5/2021 and 10/17/2021- "Eve 3 (evening shift), wound care to bilateral hips as follows: cleanse with wound cleanser, apply calcium alginate to wound bed and cover with dry dressing. Change daily every evening shift for stage IV pressure ulcer. Order Date: 09/22/2021."
- On 10/5/2021, 10/17/2021 and 10/22/2021- "Eve 3, wound care to right heel as follows: cleanse with wound cleanser, apply calcium alginate to wound bed and cover with dry

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dressing. Change daily every evening shift for stage III pressure ulcer. Order Date: 09/22/2021."

The progress notes for Resident #29 failed to evidence documentation of the treatments listed above completed on the dates listed above.

On 12/1/2021 at 3:20 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that treatments were completed as ordered and documented on the eTAR. LPN #9 stated that if there were blanks on the eTAR in the treatment areas that the nurse who was working that day probably forgot to sign off on it after they did the treatment.

On 12/1/2021 at 4:30 p.m., an interview was conducted with LPN #10. LPN #10 stated that treatments were documented on the eTAR after they were completed. LPN #10 stated that nurses often get busy or pulled away for an emergency and may forget to sign off on the treatments. LPN #10 stated that there would be blanks on the eTAR if the nurse forgot to sign off but it did not mean that the care was not provided.

On 11/29/2021 at approximately 3:15 p.m., the ASM (administrative staff member) #1, the interim administrator was asked about the standard of practice that the facility nurse's follow. ASM #1 stated that they would look into it. At approximately 4:50 p.m. ASM #1 stated that the nursing staff follow Lippincott as their standard of practice.

On 11/29/2021 at 5:40 p.m., ASM #1 provided via email a copy of the cover and table of contents

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for "Lippincott Nursing Eighth Edition Procedures, 2019."

According to Fundamentals of Nursing, Lippincott Williams and Wilkins Philadelphia 2007 page 53. "Accurate documentation shows the care that you (nurses) provide meets the patient's needs and expressed wishes. It proves you are following the accepted standards of nursing care mandated by the law, your profession, and your health care facility..." and on page 93, "The medical record is the main source of information and communication among nurses, doctors, physical therapists, social workers, and caregivers. Everyone's notes and documentation is important because together they represent a complete picture of the patient's care."

On 12/1/2021 at approximately 5:10 p.m., ASM #1, the interim administrator, ASM #2, the director of nursing, ASM #4, the regional director of clinical operations and ASM #5, the regional vice president of operations were made aware of the findings.

No further information was provided prior to exit.

References:

1. Sepsis: An illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: <https://medlineplus.gov/ency/article/000666.htm>.

2. Gastrostomy (G-Tube): A gastrostomy feeding

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tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. This information was obtained from the website: https://medlineplus.gov/ency/article/002937.htm.

3. Pressure ulcer: A pressure sore is an area of the skin that breaks down when something keeps rubbing or pressing against the skin. Pressure sores are grouped by the severity of symptoms. Stage I is the mildest stage. Stage IV is the worst. Stage I: A reddened, painful area on the skin that does not turn white when pressed. This is a sign that a pressure ulcer is forming. The skin may be warm or cool, firm or soft. Stage II: The skin blisters or forms an open sore. The area around the sore may be red and irritated. Stage III: The skin now develops an open, sunken hole called a crater. The tissue below the skin is damaged. You may be able to see body fat in the crater. Stage IV: The pressure ulcer has become so deep that there is damage to the muscle and bone, and sometimes to tendons and joints. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000740.htm.

F 842

F 867 QAPI/QAA Improvement Activities
SS=E CFR(s): 483.75(g)(2)(ii)

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee must:
(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;
This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document

F 867 **F867**

1. LNHA met with Medical Director and reviewed past QAPI minutes.

2. Current residents in the center have the potential to be affected.

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review, it was determined that the facility staff failed to maintain an effective Quality Assurance program.

The facility staff failed to ensure the physician attended quarterly quality assurance meetings for three of three quarters

The findings include:

On 12/02/2021 at approximately 10:30 a.m., a review of the facility, "QAPI [quality assurance performance improving] Meeting" sign-in sheets" dated April 2021 through October 2021 failed to evidence the signature of the facility's medical director.

On 12/02/2021 at approximately 10:45 a.m., an interview was conducted with ASM [administrative staff member] # 1, interim administrator, regarding the missing signature of the medical director for the dates listed above. When asked about the missing signature of the facility's medical director ASM # 1 stated that they did not have any evidence that the medical director had attended.

The facility's policy "Quality Assurance Improvement Process" documented in part, "Procedure: 1. The committee may consist of: A. Medical Director. B. Administrator. C. Director of Nursing. D. At least three other staff members, which may include: i. Rehabilitation Manager, ii. Social Worker, iii. Activities Director, iv. Medical Records, v. Designated Staff Development, vi. Director of Dining Services, vii. Business Office, viii. Employee Health, ix. Laboratory Services Representative, x. Others as deemed by committee on consultant basis, xi. Pharmacy

3. The Administrator/designee will re-educate Medical Director that attendance is required at least quarterly.

4. Quarterly schedule of QAPI meetings will be sent to Medical Director. Attendance of required team members will be audited monthly. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately.

5. Compliance Date: 01/04/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 120 Consultant." No further information was provided by the end of the survey.	F 867		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure CNAs (certified nursing aides) completed required annual in-service training for two of five CNA record reviews, CNA #2 and CNA #8. The facility staff failed to ensure CNA #2 and CNA #8 completed annual dementia training.	F 947	**F947** 1. CNA #2 and CNA #8 remain employed at the center. Dementia education was completed. 2. Current CNA's in the center have the potential to be affected. 3. The Administrator provided re-education to the DON and HR Director regarding the requirement for annual CNA training. 4. A report will be generated of annual dementia training completions weekly, for one month. Results will be presents to QAPI monthly for continued monitoring. Any noted trends will be addressed immediately. 5. Compliance Date: 01/04/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495140	A. BUILDING _____ B. WING _____	C 12/02/2021

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F 947	Continued From page 121	F 947		

The findings include:

CNA #2 was hired on 12/16/16. Review of CNA #2's record failed to reveal evidence that the CNA had completed annual dementia training.

CNA #8 was hired on 12/16/16. Review of CNA #8's record failed to reveal evidence that the CNA had completed annual dementia training.

On 12/1/21 at 4:56 p.m., an interview was conducted with ASM (administrative staff member) #5 (the regional vice president of operations). ASM #5 stated dementia training should be completed annually by the CNAs within the computer training system and the human resources department tracks the percentage of completion in the computer training system. At this time, ASM #1 (the interim administrator), ASM #2 (the director of nursing), ASM #4 (the regional director of clinical operations) and ASM #5 were made aware of the above concern.

On 12/2/21 at 10:20 a.m., ASM #1 stated the facility did not have a policy regarding required annual CNA training.

No further information was presented prior to exit.