STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	07/29/2021

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APPOMATTOX HEALTH & REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 7/27/2021 through 7/29/2021. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 7/27/2021 through 7/29/2021. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 15 current Resident reviews and three closed record reviews.	F 000		
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 staff interview and clinical record review, the facility staff failed to complete an accurate Minimum Data Set (MDS) for one of eighteen residents in the survey sample, Resident #45. An admission MDS for Resident #45 inaccurately assessed the presence of pressure ulcers.	F 641	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all	9/10/21

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

Electronically Signed | 08/16/2021

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F 641	Continued From page 1 The findings include: Resident #45 was admitted to the facility on 6/25/21 with diagnoses that included right hip peri-prosthetic fracture, humerus fracture, congestive heart failure, atrial fibrillation, chronic kidney disease, anemia, hypothyroidism and urinary tract infection. The MDS dated 6/30/21 assessed Resident #45 as cognitively intact. A weekly skin evaluation sheet dated 6/25/21 documented the resident was assessed upon admission with the following skin impairments: Left buttock - stage II pressure ulcer measuring 0.5 x 0.3 x 0.0 (length x width x depth in centimeters); Sacrum - skin tear measuring 0.8 cm x 0.5 cm x 0 cm. The assessment documented, "Alevyn foam to sacrum and left buttock q [every] three days. Bruising to right trochanter noted. Bruising to left shoulder note. No other open areas observed at this time." Another skin assessment was completed on 6/28/21 and documented the resident had, "...stage 2 pressure areas to coccyx, right buttock and left buttock. Treatments changed this shift per wound protocol..." Section M of Resident #45's admission MDS with assessment reference date of 6/30/21 documented the resident currently had three (3) stage 2 pressure ulcers. The MDS documented the three pressure ulcers were present upon admission even though the admission assessment documented only one pressure ulcer on the left buttock. On 7/28/21 at 1:50 p.m., the Registered Nurse Unit Manager (RN #1) was interviewed about the	F 641	federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated F641 1. The MDS for Resident #45 was modified 7/28/21 with correct pressure ulcer documented while surveyors were on sight. 2. An audit was conducted by the Director of Nursing to identify Residents with pressure ulcers upon admission and documented skin assessments for the month of July to ensure accurate MDS. 3. Staff Development Coordinator or designee will educate Nursing staff on the importance of accurate skin assessments upon admission and verified by an RN within 24 hours of admission. 4. The Director of Nursing and/or designee will review admission skin assessments for accuracy for four weeks. 5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed. Date of Compliance 9/10/2021	

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F 641	Continued From page 2	F 641		

how the three pressure ulcers were categorized as present on admission when the right buttock and coccyx pressure ulcers were not assessed until three days after admission on 6/28/21. RN #1 stated she usually performed a follow up skin assessment within 24 hours of a resident's admission to verify the assessment. RN #1 stated Resident #45 was admitted on a Friday (6/25/21) and she did not perform her assessment until Monday, 6/28/21. RN #1 stated the resident had three stage 2 pressure ulcers (left buttock, right buttock and coccyx) when she assessed him on 6/28/21. RN #1 stated she did not assess the resident upon admission on 6/25/21 so could not verify the accuracy of the admission assessment.

On 7/28/21 at 2:05 p.m., the Registered Nurse MDS Coordinator (RN #2) was interviewed about coding Resident #45's pressure ulcers as present on admission when the admission assessment indicated only one pressure ulcer. RN #2 stated if she noticed something conflicting about assessments she usually talked with nursing or would perform her own assessment. RN #2 stated she did not know how she determined the three pressure ulcers were present on admission. RN #2 stated the resident was admitted on a Friday (6/25/21) and the assessment indicating three pressure ulcers was not performed until three days after admission.

The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual on page M-8 documents concerning pressure ulcer assessment, "...For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in

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F 641	Continued From page 3 the care of the nursing home..." The RAI manual on page M-8 lists the definition of on admission as, "As close to the actual time of admission as possible." Page M-13 of the RAI Manual documents concerning coding of pressure ulcers in section M0300B2, "...Enter the number of these Stage 2 pressure ulcers that were first noted at the time of admission/entry...Enter 0 if no Stage 2 pressure ulcers were first noted at the time of admission/entry or reentry..." (1) These findings were reviewed with the administrator and director of nursing during a meeting on 7/28/21 at 3:30 p.m. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, Centers for Medicare & Medicaid Services, Revised October 2019.	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	F 656		9/10/21

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F 656	Continued From page 4 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care 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, the facility staff failed to develop a comprehensive care plan for one of eighteen residents in the survey sample, Resident #24. Resident #24 had no plan of care regarding behaviors and use of an anticoagulant. The findings include: Resident #24 was admitted to the facility on 3/9/21 with diagnoses that included dementia with behavioral disturbance, rectal prolapse, congestive heart failure, COPD (chronic	F 656	F656 1. 8/11/21 care plan updated for Resident #24 with behaviors and use of an anticoagulant. 2. An audit was conducted by the Director of Nursing to identify Residents with behaviors or Residents currently on anticoagulants for the month of July to ensure accurate documentation was reflected in the care plan. 3. Staff Development Coordinator or designee will educate Nursing staff about	

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F 656	Continued From page 5 obstructive pulmonary disease), chronic kidney disease, anemia, atrial fibrillation, osteoarthritis, hypertension and gout. The Minimum Data Set (MDS) dated 6/25/21 assessed Resident #24 with severely impaired cognitive skills. Resident #24's clinical record documented the resident was admitted with a diagnosis that included dementia with behavioral disturbance. Resident #24's clinical record documented the following nursing behavior notes. 3/11/21 - "...Increasingly agitated with staff when asked to sit down...re-direct with no success..." 3/16/21 - "Resident exit seeking. Nurse and CNA [certified nurses' aide] attempted to redirect resident. No Success..." 4/26/21 - "Resident extremely tearful following roommate pulling back covers on bed resident made independently...is inconsolable and tearful..." 6/7/21 - "Resident observed rummaging through roommate's closet...later observed wearing roommate's clothes...oriented to location of her belongings..." 6/20/21 - "Resident observed by another resident pulling her roommate into the floor from her bed...Removed her from the room for short period..." Resident #24 was prescribed the antipsychotic medication Seroquel at each bedtime for management of behaviors. The clinical record also documented a physician's order dated 3/9/21 for the anticoagulant Rivaroxaban 15 milligrams each day for the prevention of deep vein thrombosis. Resident #24's plan of care (revised 6/22/21)	F 656	the importance of accurate documentation related to behaviors and anticoagulants. 4. Director of Nursing or designee will review behaviors notes and MD orders for anticoagulants to ensure accuracy of care plan information weekly for four (4) weeks. 5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed. Date of Compliance 9/10/2021	

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F 656	Continued From page 6	F 656		

included no problems, goals and/or interventions regarding the resident's behaviors or anticoagulant use. The care plan listed the resident used the antipsychotic medication Seroquel for behavior management but did not identify any of the resident's actual behaviors. The only intervention listed concerning use of Seroquel was, "Monitor for side effects and effectiveness."

On 7/28/21 at 2:00 p.m., the Registered Nurse (RN #1) responsible for updating care plans was interviewed about Resident #24. RN #1 stated the resident had an episode of pulling the roommate while in bed, exit seeking, pilfering in roommate's clothes, going in other residents' rooms and at times was agitated. RN #1 stated they usually offered the resident snacks, redirection or got activities involved when the resident exhibited behaviors. RN #1 reviewed the care plan and stated she did not see anything on the plan about behaviors.

On 7/29/21 at 8:17 a.m., the Director of Nursing (DON) was interviewed about Resident #24's behaviors and care plan. The DON stated the resident rummaged in others' belongings, was exit seeking and had an incident of putting a hairbrush in her brief.

On 7/29/21 at 9:22 a.m., the unit manager (RN #1) and RN #4 that cared for Resident #24 were interviewed about the hairbrush incident. RN #4 stated that about two months ago she overheard a CNA state a hairbrush with stool on it fell out of the resident's brief during a shower. RN #4 stated Resident #24 was known to put items in her incontinence brief. RN #4 stated she did not document the hairbrush incident and it had not

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F 656	Continued From page 7 been added to the care plan. RN #1 stated Resident #24's care plan did not mention the resident putting items in her brief, the hairbrush incident or use of an anticoagulant. These findings were reviewed with the administrator and director of nursing during a meeting on 7/29/21 at 11:30 a.m.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow professional standards of practice for one of eighteen residents in the survey sample, Resident #24. Nursing failed to document an incident and physical assessment of Resident #24 after a hairbrush was found in her incontinence brief. The findings include: Resident #24 was admitted to the facility on 3/9/21 with diagnoses that included dementia with behavioral disturbance, rectal prolapse, congestive heart failure, COPD (chronic obstructive pulmonary disease), chronic kidney disease, anemia, atrial fibrillation, osteoarthritis, hypertension and gout. The Minimum Data Set (MDS) dated 6/25/21 assessed Resident #24 with severely impaired cognitive skills.	F 658	F658 1. Care Plan on Resident #24 updated 7/29/21 with specific behavior, such as placing items in incontinent brief and on person. 2. An audit was conducted by the Director of Nursing during the month of July to identify Residents with behaviors to ensure documentation and physical assessments were provided as needed and care plan updated. 3. Staff Development Coordinator will educate Nursing staff to follow professional standards of practice by ensuring documentation and physical assessments are charted at the time care is rendered and care plans updated. 4. Director of Nursing or designee will review daily Unit Manager huddle	9/10/21

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F 658	Continued From page 8 On 7/29/21 at 8:17 a.m., the Director of Nursing (DON) was interviewed about Resident #24's behaviors related to use of the antipsychotic medication Seroquel. The DON stated the resident rummaged in others' belongings, was exit seeking and had a recent incident of putting a hairbrush in her brief/rectum. Resident #24's clinical record and plan of care made no mention of any items, including a hairbrush found in the resident's brief. On 7/29/21 at 9:22 a.m., the Registered Nurse Unit Manager (RN #1) was interviewed about Resident #24's incident with the hairbrush. RN #1 stated RN #4 was caring for Resident #24 at the time of the hairbrush incident and the resident was known to put items in her brief. RN #1 stated the resident took an anticoagulant medication daily but no rectal bleeding issues were reported for Resident #24 following the incident. RN #1 stated nothing was documented in the nursing notes about the incident or other events of finding items in the resident's incontinence brief and this behavior had not been added to the care plan. RN #1 stated RN #4 should have documented in the clinical record the hairbrush incident including her assessment of the resident and listed the incident in the provider book for review. On 7/29/21 at 9:23 a.m., RN #4 was interviewed about Resident #24 and the hairbrush incident. RN #4 stated the incident occurred during an evening shift. RN #4 stated she did not remember the exact day but it was "probably two months ago." RN #4 stated she overheard a CNA (Certified Nurses' Aide) talking about a hairbrush found in the resident's rectum and	F 658	communications for four (4) weeks to ensure compliance. 5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed. Date of Compliance 9/10/2021	

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F 658	Continued From page 9	F 658		

having to remove it. RN #4 stated she asked the CNA about what happened and the CNA reported that when she removed the resident's incontinence brief in the shower room, a hairbrush with stool on it fell onto the floor. RN #4 stated the CNA denied seeing the hairbrush inserted in the resident's rectum or removing it from the rectum. RN #4 stated the CNA had not reported the hairbrush incident. RN #4 stated she put the resident in bed, inspected, palpated and assessed the resident's rectal area and saw no blood, open areas or signs of trauma. RN #4 stated she reported the incident verbally during shift change but did not make a note or document her assessment of the resident. When asked about why she made no documentation of her assessment or the situation, RN #4 stated she did not make a note because her assessment found no problems/trauma. RN #4 stated the resident was known to put personal items in her brief. RN #4 stated she did not remember the reporting CNA's name and thought she no longer worked at the facility.

On 7/29/21 at 9:41 a.m., the DON and corporate consultant were interviewed again about Resident #24 and behaviors that included putting personal items in her incontinence brief. The DON stated nurses verbally told her about the hairbrush incident. The corporate consultant stated a prudent nurse would care plan the behaviors so that all the nursing staff were aware and could intervene to keep the resident safe.

The Lippincott Manual of Nursing Practice 11th edition on page 15 documents concerning standards of practice, "...A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the

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F 658	Continued From page 10 nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events...Legal claims most commonly made against professional nurses include the following departures from appropriate care: failure to assess the patient properly or in a timely fashion...follow appropriate nursing measures, communicate information about the patient...document appropriate information in the medical record..." (1) (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2019.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to follow physician orders for 1 of 18 residents in the survey sample, Resident #6. Fluid intake was not monitored and documented for Resident #6. The findings include:	F 684	F684 1. MAR for Resident #6 was modified 7/29/21 and updated 8/11/21 to reflect fluid restriction of 1500 ml/daily. 2. An audit conducted by the Director of	9/10/21

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F 684	Continued From page 11 Resident #6 was originally admitted to the facility on 02/28/2017 and readmitted on 07/23/2021 with diagnoses that included paraplegia, type 2 diabetes, depression, end stage renal disease, renal dialysis dependent, colostomy, congestive heart failure, and hypertension. The Admission assessment dated 07/23/21 assessed Resident #6 as alert and oriented to person, place, time and situation. On 07/27/2021 Resident #6's clinical record was reviewed. Observed on the physician's order summary was the following order: " ...1500ml (milliliters)/day fluid restriction every shift. Order Date: 07/23/2021. Start Date: 07/23/2021..." Observed on the care plans was the following focus area: "...The resident has potential fluid deficit/excess r/t (related to) dialysis, non-compliant with fluid restriction and diet. Created on: 01/04/2017. Revision on: 07/23/2021." Interventions included the following: "...iEnsure that all beverages offered comply with diet/fluid restrictions and consistency requirements...." A review of the clinical record did not include documentation of the fluid intake. On 07/28/21 at 2:16 p.m., the Licensed Practical Nurse (LPN #2) who routinely provided care for Resident #6 was interviewed regarding the documentation for the fluid intake for residents on fluid restriction. LPN #2 stated the fluid intake documentation should have been on the Medication Administration Record (MAR). LPN #2 reviewed the MAR and stated she did not see the documentation. LPN #2 continued and stated	F 684	Nursing to identify Residents for fluid restrictions for the month of July were entered correctly and carried over to the MAR for monitoring q shift. 3. Staff Development Coordinator or designee will educate Nursing staff on importance of entering physician fluid restriction orders accurately to carry over to the MAR for monitoring q shift 4. Director of Nursing or designee will review fluid restriction orders entered by Nursing to ensure accuracy for four weeks. 5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed. Date of Compliance 9/10/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH & REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 684	Continued From page 12 upon further review, the fluid restriction order was not entered correctly at readmission and did not transfer over to the MAR so it was not flagged for monitoring and/or documentation each shift. On 07/28/2021 at 3:19 p.m. the above findings were shared with the administrator, director of nursing, and corporate consultant.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to perform a pressure ulcer dressing change in a manner to prevent infection for one of eighteen residents in the survey sample. Nursing failed to follow infection control practices during a dressing change to Resident #45's pressure ulcers. The findings include:	F 686	F686 1. On 8/10/21 an in-service was provided to LPN #2 how to perform a pressure ulcer dressing change in a manor to prevent infection and to follow infection control practices for Resident #45. 2. An audit was conducted by the Director of Nursing or designee for the month of August to identify Residents with	9/10/21

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	495188	A. BUILDING _____ B. WING _____	07/29/2021

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F 686	Continued From page 13 Resident #45 was admitted to the facility on 6/25/21 with diagnoses that included right hip peri-prosthetic fracture, humerus fracture, congestive heart failure, atrial fibrillation, chronic kidney disease, anemia, hypothyroidism and urinary tract infection. The MDS dated 6/30/21 assessed Resident #45 as cognitively intact. Resident #45's clinical record documented the resident was currently treated for a stage 2 pressure injury on the sacrum and the left buttock. A physician's order dated 7/21/21 required cleansing the pressure ulcers with wound cleanser, Hydrogel to the wound bed, and a silicone foam dressing each day. On 7/28/21 at 11:12 a.m., with the resident's permission, Licensed Practical Nurse (LPN) #2 was observed performing a dressing change to Resident #45's pressure ulcers. LPN #2 washed her hands, put on gloves, pulled the privacy curtain, pulled back bed covers and assisted the resident with positioning in bed onto his right side. LPN #2 then pulled down the resident's shorts and incontinence brief. The resident had a linear open ulcer on the sacrum approximately 1.75 inches in length and an irregular shaped open area on the left buttock approximately .25 inches wide. Without prior hand hygiene or glove change, LPN #2 applied wound cleanser to a gauze and cleansed the sacral wound. LPN #2 repeated the same cleansing for the left buttock wound with a clean gauze soaked with cleanser. LPN #2 positioned the silicone foam dressing on the bed covers and wrote her initials and date on the dressing. LPN #2 then put Hydrogel onto a wooden applicator (tongue depressor) and applied the gel to the linear sacral ulcer. Using the same applicator, LPN #2 put additional	F 686	pressure ulcers to ensure infection control practices are met during dressing changes. 3. Staff Development Coordinator or designee will educate the Nursing staff on infection control practices specifically during pressure ulcer wound dressing changes. 4. Director of Nursing or designee will review treatment observations for four (4) weeks to ensure compliance. 5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed. Date of Compliance 9/10/2021	

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	495188	A. BUILDING _____ B. WING _____	07/29/2021

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F 686	Continued From page 14	F 686		

Hydrogel from the tube onto the applicator, touching the tube opening with the used applicator. Using the same applicator, LPN #2 applied Hydrogel to the left buttock ulcer. LPN #2 then placed the silicone foam dressing covering both ulcers. LPN #2 assisted the resident with his clothing, repositioned the resident in bed, discarded gloves and supplies and then washed her hands. There was no hand hygiene or glove changes after cleansing the wounds and prior to application of the Hydrogel. The same applicator was used for both wounds and the applicator touched the Hydrogel tube opening after contact with the sacral ulcer.

On 7/28/21 at 11:25 a.m., LPN #2 was interviewed about lack of hand hygiene and using the same applicator between wounds. LPN #2 stated she should have washed hands and put on new gloves after cleansing the wounds. LPN #2 stated she used the same applicator for both wounds but "flipped" the tongue depressor, using one side for the sacral ulcer and the other side for the left buttock wound. When asked about touching the Hydrogel tube opening with the soiled applicator, LPN #2 stated the tube of Hydrogel was dedicated for Resident#45 and not used with other residents.

On 7/28/21 at 2:30 p.m., the Registered Nurse (RN #3) responsible for the facility's infection control program was interviewed about Resident #45's observed dressing change. RN #3 stated once LPN #2 positioned and prepared the resident, she should have performed hand hygiene and put on new gloves prior to cleansing the wounds. RN #3 stated the nurse should have used a clean applicator for each wound and the applicator should not make contact with the

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	495188	A. BUILDING _____ B. WING _____	07/29/2021

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F 686	Continued From page 15	F 686		

Hydrogel supply tube after touching a wound.

The facility's policy titled General Wound Care/Dressing Changes (effective 11/1/19) documented, "...Licensed nurses will follow recognized standards of practice regarding dressing change (s)..." The facility provided a dressing change protocol (undated) that included the following steps, "...Perform hand hygiene...Gather necessary equipment...Prepare environment, position patient...Perform hand hygiene...Apply non-sterile gloves...Cleanse wound using one 2 x 2 gauze per stroke...Discard non-sterile gloves...Apply outer dressing, keeping the inside of the sterile dressing touching the wound...Discard used equipment...Perform hand hygiene..."

The National Pressure Injury Advisory Panels (NPIAP) defines a pressure injury as, "...localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear..." The NPIAP defines a stage 2 pressure injury as, "Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present..." (1)

This finding was reviewed with the administrator and director of nursing during a meeting on 7/28/21 at 3:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	07/29/2021

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F 686	Continued From page 16 (1) NPIAP Pressure Ulcer Stages/Categories. National Pressure Injury Advisory Panel. 7/30/21. https://npiap.com/page/PressureInjuryStages	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure proper wheelchair positioning for 1 of 18 residents in the survey sample, Resident #36. Resident #36 was observed seated in a wheelchair without footrests and her feet not touching the floor. The findings include: Resident #36 was admitted to the facility on 06/28/2019 with diagnoses that included	F 688	F688 1. On 7/29/21 occupational therapy evaluated Resident #36 with the following recommendations: Resident to remain in current wheelchair with addition of elevating leg rests and custom foot stop drop with lateral barriers to prevent decrease in ROM/mobility. 2. An audit conducted by the Director of Nursing for any residents with wheelchair positioning needs for the month of August.	9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	07/29/2021

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F 688	Continued From page 17 dementia without behavioral disturbance, hypertension, dysphasia, depression, anxiety, and gastro-esophageal acid reflux (GERD). The most recent Minimum Data Set (MDS) dated 06/30/2021 was a Quarterly assessment and assessed Resident #36 as severely impaired for daily decision making and having long and short term memory problems. Under Section G - Function Status, the MDS assessed Resident #36 requiring extensive assistance with one-person physical assistance for locomotion /mobility with the use of a wheelchair. On 07/27/2021 during the initial tour, Resident #36 was observed seated in her wheelchair in her room. The wheelchair had no footrests and the resident's feet were dangling, not reaching the floor. Resident #36's toes were pointed downward and were approximately 2 inches from the floor. On 07/27/2021 at 12:15 p.m. and 4:00 p.m., Resident #36 was observed in her wheelchair again, with her feet dangling, not reaching the floor; there were no footrests observed on the wheelchair. On 07/28/2021 at 7:41 a.m. and 8:32 a.m., Resident #36 was observed seated in her wheelchair beside her bed with her feet dangling, not reaching the floor, and no footrests observed on the wheelchair. On 07/28/2021 at 8:33 a.m., the Certified Nursing Assistant (CNA #1) who routinely provides care for Resident #36 was interviewed and asked if Resident #36 was able to self-propel the wheelchair. CNA #1 stated, "No, we have to push her in the wheelchair." CNA #1 was asked if Resident #36 had footrests for her wheelchair.	F 688	3. Staff Development Coordinator or designee to educate staff on importance of proper wheelchair positioning to prevent decrease in ROM/mobility. 4. Director of Rehab or designee will review Resident for proper wheelchair positioning needs for four (4) weeks to increase/prevent decrease in ROM/mobility. 5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed. Date of Compliance 9/10/2021	

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	495188	A. BUILDING _____ B. WING _____	07/29/2021

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F 688	Continued From page 18 CNA #1 stated, "No, I don't think so." On 07/28/2021 at 11:09 a.m., Resident #36 was observed seated in her wheelchair with bilateral footrests attached to the wheelchair. On 07/28/2021 at 11:11 a.m., the unit manager (RN #1) was interviewed regarding the recent observation of footrests attached to Resident #36's wheelchair. RN #1 stated, "We asked therapy to assess the resident today." RN #1 was asked if Resident #36 had the footrests before today. RN #1 stated, "No, I won't lie she didn't have them before today." A review of the Occupational Therapy Addendum documented the following: "...Postural Deviations: Pt (Patient) maintains pelvis centerback and upright trunk with current seating devices, however BLEs (bilateral lower extremities) without floor contact (1-1.5 inches clearance) or presence of leg rests. Pt (Patient) noted with decreased position in space with noted restless movements of LEs (lower extremities) during eval time...Plan:...Pt will require foot stop/drop with elevating leg rests to improve LE (lower extremity) alignment and decrease risk of injury from w/c (wheelchair) parts." On 07/28/2021 at 3:19 p.m. the above findings were shared with the administrator, director of nursing, and corporate consultant.	F 688		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	07/29/2021

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F 725	Continued From page 19 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident interviews, facility document review, and staff interview, the facility staff failed to respond to call bells in a timely manner for 5 of 18 residents in the survey sample, Resident #15, #50, #45, #6 and #34. All five residents stated that due to staffing, it takes a long time to answer call bells. Staffing issues were also annotated in the July resident council minutes. The findings include: Resident #15 was originally admitted to the facility on 10/04/2017 and readmitted on 04/05/2020.	F 725	F725 1. On 8/11/21 Unit Manager met with Residents #15, #50, #60, #34 to address call bell concerns. Resident #45 discharged home 8/11/21. Agency staff contracted 7/28/21. 2. An audit was conducted by the Director or Nursing or designee to identify Residents with call bell response time concerns to ensure call bell timeliness and compliance. 3. Staff Development Coordinator or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	07/29/2021

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F 725	Continued From page 20	F 725		

The most recent Minimum Data Set (MDS) dated 05/24/2021 was a Quarterly assessment and assessed Resident #15 as cognitively intact for daily decision making with a score of 15 out of 15.

On 07/27/2021 at 10:51 a.m. during the initial tour, Resident #15 was interviewed regarding call bell response time. Resident #15 stated, "I have to wait 15 to 30 minutes sometimes. I have to stay in the bathroom 30 minutes. I used to time them, but my watch is broken."

Resident #50 was admitted to the facility on 10/02/2019. The most recent MDS, dated 07/06/2021 was a Significant Change and assessed Resident #50 as cognitively intact for decision making with a score of 15 out of 15.

On 07/27/2021 at 11:04 a.m., Resident #50 was interviewed regarding call bell response time. Resident #50 stated, "You hate to call them anytime because they are short of help. It all depends on the time of day to wait on their response. They are good to me, but they do not have enough help. I feel sorry for the ones working. I hate to call them because there are not enough working."

Resident #45 was admitted on 06/25/2021. The most recent MDS, dated 06/30/2021 was the 5-day Admission assessment and assessed Resident #45 as cognitively intact for daily decision making with a score of 14 out of 15.

On 07/27/2021 at 2:17 p.m., Resident #45 was interviewed regarding call bell response time. Resident #45 stated, "You pretty much have to wait especially in the morning during breakfast. It seems like it takes longer for them to answer the

designee will educate Nursing staff on the importance of responding timely to call bells. Human Resources focus will be on recruitment and retention of staff.
4. Director of Nursing or designee will review the current staff/Agency staff schedule to ensure sufficient staff to address Residents call bell concerns.
5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed.
Date of Compliance 9/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH & REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

(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 725	Continued From page 21	F 725		

bell from the room, it is quicker when you ring from the bathroom."

Resident #Resident #6 was originally admitted to the facility on 02/28/2017 and readmitted on 07/23/2021. The Admission assessment dated 07/23/21 assessed Resident #6 as alert and oriented to person, place, time and situation.

On 07/27/2021 at 3:43 p.m., Resident #6 was interviewed regarding call bell response time. Resident 36 stated, "Staffing could be better. We have 2 CNAs (Certified Nursing Assistants) and 1 nurse on third shift. Some of the staff are overworked which causes them stress and adds to the stress of us residents. They need more help. Call bell times can fluctuate depending on who you have working and the number of staff working. Sometimes you can have a nurse and/or CNA who is just tired and over worked so they move slower. Other times you can have someone who just doesn't care and they don't want to be here so they do the bare minimum."

Resident #34 was originally admitted to the facility on 06/28/2018 and readmitted on 04/13/2020. The most recent MDS dated 06/26/2021 was a Quarterly assessment and assessed Resident #34 as cognitively intact for daily decision making with a score of 14 out of 15.

On 7/27/2021 at 3:54 p.m., Resident #34 was interviewed regarding call bell response time. Resident #34 stated, "It seems to be short of staff. It takes a long time for them to answer the call bell. I try not to call at night."

On 07/28/2021, the Resident Council meeting minutes were reviewed for the period of January

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	07/29/2021

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APPOMATTOX HEALTH & REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

(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 725	Continued From page 22	F 725		

2021 through July 2021.

Observed on the May 2021 minutes was the following: "....Needing more staff was voiced. Hiring and recruiting on going, bonuses and incentives implemented...."

Observed on the June 14, 2021 minutes was the following: " ....Nursing: need more CNAs ...."

Observed on the July 13, 2021 minutes was the following, " ....Need more CNAs, waiting longer for assistance...."

A review of the as worked schedule for the period of 07/14/2021 through 07/26/2021 documented first shift staffing included 2-3 nurses and 4-5 CNAs; second shift staffing included 2 nurses and 3-5 CNAs; and third shift included one nurse and 2 CNAs.

On 07/28/2021 at 3:19 p.m., the facility's administrative team that included the administrator, director of nursing and corporate consultant were interviewed regarding call bell response time and adequate staffing. The corporate consultant and the administrator stated the expectation was for staff to answer the call bells within 5 to 10 minutes to at least acknowledge the call bell and either respond to the resident's needs or let the resident know they will return in a few minutes or send someone else to respond if they were unable to respond themselves. The administrator stated the facility is in the process of contracting with an agency for staffing needs. However, one of the challenges they have encountered is finding agency staff who are vaccinated and/or will be become vaccinated to work at the facility because it is

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	495188	A. BUILDING _____ B. WING _____	07/29/2021

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APPOMATTOX HEALTH & REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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F 725	Continued From page 23 company policy to have the COVID-19 vaccination. The corporate consultant and administrator both stated virtual school was another challenge in finding staff because parents often had to be home with their children. The administrator stated the facility had lost some staff and have implemented bonuses and other incentives to help recruit staff. The administrator continued and stated they recognized the current staff are working extended hours to meet the residents' needs; however, they need time off to avoid burnout. The administrator stated previously housekeeping and dietary staff were able to assist with non-direct care ancillary tasks. However now those two departments are contract employees and are no longer able to assist with these tasks so everything is falling on the direct care staff (CNAs and nurses). No other information was presented to the survey time prior to exit on 07/29/2021 at 11:30 a.m.	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		9/10/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 756	Continued From page 24 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review, and staff interview, the facility staff failed to provide a rational for pharmacy recommendations for 2 of 18 residents in the survey sample, Resident #36 and Resident #24. The facility physician failed to provide a rational for a pharmacy recommendation for Donepezil 10 mg (Aricept) and Memantine 5 mg (Namenda). The facility physician failed to provide a rational for a pharmacy recommendation for Seroquel for Resident #24. The findings include:	F 756	F756 1. In-serviced Dr. Gezen on 7/29/21. On 8/13/21 Medical Provider documented for Residents #24 and #36 rationale for pharmacy recommendations. 2. An audit was conducted by the Director of Nursing to identify Residents who the Medical Providers did not provide rationale for July pharmacy recommendations. 3. Staff Development Coordinator to in-service Medical Providers and Nursing staff on importance of ensuring Medical	

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F 756	Continued From page 25 1. Resident #36 was admitted to the facility on 06/28/2019 with diagnoses that included dementia without behavioral disturbance, hypertension, dysphasia, depression, anxiety, and gastro-esophageal acid reflux (GERD). The most recent Minimum Data Set (MDS) dated 06/30/2021 was a Quarterly assessment and assessed Resident #36 as severely impaired for daily decision making and having long and short term memory problems. On 07/28/2021 Resident 36's clinical record was reviewed including the pharmacy consultation report for July 9, 2021 through July 12, 2021. The report documented the following: "....[Resident #36] receives Donepezil 10 mg (milligrams) daily and Memantine 5 mg (milligrams) daily for dementia and is severely cognitively impaired, as suggested by the CPS (cognitive performance score) score of 5. Recommendation: Using a person-centered approach, please reevaluate the continued benefit for Donepezil and Memantine if appropriate, please consider a trial discontinuation of while concurrently monitoring for withdrawal symptoms..." The report included three check boxes for the Physician's Response that included accepting the recommendation as written, accepting the recommendation with modifications and declining the recommendation with documented rationale. None of the boxes were marked. There was no rationale documented for the continued use of the Donepezil and Memantine. Observed handwritten on the form where the rationale could be documented was the following: "To [Nurse Practitioner]. No new orders. cont. (continue)	F 756	Providers provide rationale for pharmacy recommendations. 4. Director of Nursing or designee will review monthly pharmacy recommendations for two (2) months. 5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed. Date of Compliance 9/10/2021	

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F 756	Continued From page 26	F 756		

same. 7/13/21." There was no physician's signature on the form. Observed on the form was the director of nursing (DON's) signature dated 7/13/21.

On 07/29/21 at 8:21 a.m. the director of nursing (DON) was interviewed regarding the process for pharmacy reviews/recommendations. The DON stated the pharmacist emails her the reviews and they are placed in the MD binder at the nurses station for the provider (doctor or nurse practitioner) to review. The DON was interviewed regarding the lack of provider not documenting a rational to continue the medications. The DON stated the provider was aware of the need to document a clinical rationale when declining pharmacy reviews. The DON stated the provider did not want to make changes to Resident #36's medication because of her behaviors related to her dementia.

No additional information was provided to the survey team prior to exit on 07/29/21 at 11:30 a.m.

2. Resident #24 was admitted to the facility on 3/9/21 with diagnoses that included dementia with behavioral disturbance, rectal prolapse, congestive heart failure, COPD (chronic obstructive pulmonary disease), chronic kidney disease, anemia, atrial fibrillation, osteoarthritis, hypertension and gout. The Minimum Data Set (MDS) dated 6/25/21 assessed Resident #24 with severely impaired cognitive skills.

Resident #24's clinical record documented a physician's order dated 3/11/21 for the antipsychotic medication Seroquel 12.5 mg (milligrams) to be given at each bedtime for dementia with behaviors. The medication

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F 756	Continued From page 27	F 756		

administration record documented the administration of Seroquel at each bedtime as ordered.

A pharmacy consultation report dated 7/12/21 documented, "...[Resident #24] has a diagnosis of dementia and receives Quetiapine [Seroquel] 12.5 mg hs [at bedtime] for dementia with behavioral disturbances...Recommendation: Please attempt a gradual dose reduction to Quetiapine with the end goal of discontinuation...Antipsychotics have a BOXED WARNING for increased risk of mortality in elderly individuals with psychosis related to dementia...If this therapy is to continue, it is recommended that...the prescriber document an assessment of risk versus benefit, indicating that it continues to be a valid therapeutic intervention for this individual..."

The physician's response section of this recommendation was blank with no indication to accept the recommendation, modify the recommendation or decline the recommendation. There was no physician or provider signature on the form. The director of nursing documented a note at the bottom of the form stating, "T.O. [telephone order]...No New orders - cont [continue with] current dose." There was no clinical rationale documented for continuing the medication.

On 7/29/21 at 8:17 a.m., the Director of Nursing (DON) was interviewed about the lack of physician/provider response to Resident #24's pharmacy recommendation for a Seroquel dose reduction. The DON stated she gets an email from pharmacy each month that includes any recommendations from medication regimen

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F 756	Continued From page 28 reviews. The DON stated the recommendations were placed in a book at the nursing station for physician/provider response. The DON stated the physician/provider had been in the facility since Resident #24's review but did not respond to the recommendation. The DON stated she called the nurse practitioner about the recommendation and the order was given to continue the medication. The DON stated the physician/provider documented no rationale to continue the medication. The DON stated the providers were aware of the requirement to document responses to pharmacy recommendations and clinical rationales to continue antipsychotics but she has had trouble getting timely responses. This finding was reviewed with the administrator and director of nursing during a meeting on 7/29/21 at 11:00 a.m.	F 756		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on a medication pass observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5 %. A medication pass resulted in two errors out of 27 opportunities for an error rate of 7.41%. The findings include:	F 759	F759 1. Notified Medical Provider 7/27/21 of medication administration error for Resident # 46 Medical Provider consulted, no adverse effects, no new orders. In-serviced LPN #3 7/29/21 on	9/10/21

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F 759	Continued From page 29 On 7/27/21 at 3:52 p.m., Licensed Practical Nurse (LPN #3) was observed preparing and administering medications to Resident #46. Included in medications administered to Resident #46 was aspirin 81 mg (milligrams) enteric coated and two tablets of Senna 8.6 mg. Resident #46's clinical record documented a physician's order dated 6/28/21 for aspirin 81 mg chewable to be administered once per day for heart health. The record documented a physician's order dated 6/28/21 for Senna Plus (senna + docusate) 8.6 mg/50 mg with instructions for two tablets to be administered twice per day for constipation prevention. On 7/28/21 at 11:46 a.m., the Registered Nurse Unit Manager (RN #1) was interviewed about orders not followed for the aspirin and Senna during the medication pass to Resident #46. RN #1 reviewed the clinical record and stated the orders for the chewable aspirin and Senna Plus were correct. RN #1 stated the chewable aspirin was not in the medication cart at the time of the medication pass but was available in the medication storage room. RN #1 stated the Senna Plus should have been given as ordered instead of the plain Senna. On 7/28/21 at 4:00 p.m., LPN #3 that administered medications to Resident #46 during the medication pass was interviewed. LPN #3 stated there was no supply of chewable aspirin in the cart so she gave what was available. LPN #3 stated she was not sure if chewable aspirin was in the medication storage room. Concerning the Senna instead of Senna Plus, LPN #3 stated she thought Resident #46 liked the brown tablet	F 759	Five Rights of Medication Administration, Concentration on reading medication administration orders, medical record, and medication pass. 2. A medication pass audit for August was conducted by the Director of Nursing or designee to ensure Five Rights of Medication Administration were being followed. 3. Staff Development Coordinator or designee will in-service all Nursing staff of the importance on reading medication administration orders and medical records accurately during medication pass according to Five Rights of Medication Administration. 4. Director of Nursing or designee will review medication pass observations for four (4) weeks. 5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed. Date of Compliance 9/10/2021	

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F 759	Continued From page 30 (Senna) instead of the Senna Plus. This finding was reviewed with the administrator and director of nursing during a meeting on 7/28/21 at 3:30 p.m.	F 759		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		9/10/21

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F 880	Continued From page 31 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practices during a dressing change for one of	F 880	F880 1. Inservice held with LPN #2 on 8/10/21 regarding proper hand hygiene, donning	

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F 880	Continued From page 32	F 880		

eighteen residents in the survey sample, Resident #45. A nurse failed to perform timely hand hygiene and glove changes during a dressing change for Resident #45 and applied topical medication to two wounds using the same applicator.

The findings include:

Resident #45 was admitted to the facility on 6/25/21 with diagnoses that included right hip peri-prosthetic fracture, humerus fracture, congestive heart failure, atrial fibrillation, chronic kidney disease, anemia, hypothyroidism and urinary tract infection. The MDS dated 6/30/21 assessed Resident #45 as cognitively intact.

Resident #45's clinical record documented the resident was currently treated for a stage 2 pressure injury on the sacrum and the left buttock. A physician's order dated 7/21/21 required cleansing the pressure ulcers with wound cleanser, Hydrogel to the wound bed and a silicone foam dressing each day.

On 7/28/21 at 11:12 a.m., with the resident's permission, Licensed Practical Nurse (LPN) #2 was observed performing a dressing change to Resident #45's pressure ulcers. LPN #2 washed her hands, put on gloves, pulled the privacy curtain, pulled back bed covers and assisted the resident with positioning in bed onto his right side. LPN #2 then pulled down the resident's shorts and incontinence brief. The resident had a linear open ulcer on the sacrum approximately 1.75 inches in length and an irregular shaped open area on the left buttock approximately .25 inches wide. Without prior hand hygiene or glove change, LPN #2 applied wound cleanser to a

and doffing gloves during dressing change, and appropriate use of applicators.
2. An audit for August was conducted by the Director of Nursing or designee to observe pressure ulcer wound care treatments and dressing changes to ensure infection control practices are used, including hand hygiene and donning and doffing gloves during dressing changes, and appropriate use of applicators.
3. Staff Development Coordinator or designee will in-service all Nursing staff to follow infection control practices during a pressure ulcer wound dressing change.
4. Director of Nursing or designee will review dressing change observations for four (4) weeks.
5. Any discrepancies will be brought to the attention to the QAPI meeting and addressed as needed.
Date of Compliance 9/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 33	F 880		

gauze, cleansed the sacral wound. LPN #2 repeated the same cleansing for the left buttock wound with a clean gauze soaked with cleanser. LPN #2 positioned the silicone foam dressing on the bed covers and wrote her initials and date on the dressing. LPN #2 then put Hydrogel onto a wooden applicator (tongue depressor) and applied the gel to the linear sacral ulcer. Using the same applicator, LPN #2 put additional Hydrogel from the tube onto the applicator, touching the tube opening with the used applicator. Using the same applicator, LPN #2 applied Hydrogel to the left buttock ulcer. LPN #2 then placed the silicone foam dressing covering both ulcers. LPN #2 assisted the resident with his clothing, repositioned the resident in bed, discarded gloves and supplies and then washed her hands. There was no hand hygiene or glove changes after cleansing the wounds and prior to application of the Hydrogel. The same applicator was used for both wounds and the applicator touched the Hydrogel tube opening after contact with the sacral ulcer.

On 7/28/21 at 11:25 a.m., LPN #2 was interviewed about lack of hand hygiene and using the same applicator between wounds. LPN #2 stated she should have washed hands and put on new gloves after cleansing the wounds. LPN #2 stated she used the same applicator for both wounds but "flipped" the tongue depressor, using one side for the sacral ulcer and the other side for the left buttock wound. When asked about touching the Hydrogel tube opening with the soiled applicator, LPN #2 stated the tube of Hydrogel was dedicated for Resident#45 and not used with other residents.

On 7/28/21 at 2:30 p.m., the Registered Nurse

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F 880	Continued From page 34	F 880		

(RN #3) responsible for the facility's infection control program was interviewed about Resident #45's observed dressing change. RN #3 stated once LPN #2 positioned and prepared the resident, she should have performed hand hygiene and put on new gloves prior to cleansing the wounds. RN #3 stated the nurse should have used a clean applicator for each wound and the applicator should not make contact with the Hydrogel supply tube after touching a wound.

The facility's policy titled General Wound Care/Dressing Changes (effective 11/1/19) documented, "...Licensed nurses will follow recognized standards of practice regarding dressing change (s)..." The facility provided a dressing change protocol (undated) that included the following steps, "...Perform hand hygiene...Gather necessary equipment...Prepare environment, position patient...Perform hand hygiene...Apply non-sterile gloves...Cleanse wound using one 2 x 2 gauze per stroke...Discard non-sterile gloves...Apply outer dressing, keeping the inside of the sterile dressing touching the wound...Discard used equipment...Perform hand hygiene..."

This finding was reviewed with the administrator and director of nursing during a meeting on 7/28/21 at 3:30 p.m.