STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495086	A. BUILDING _____ B. WING _____	10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY POINTE REHABILITATION AND NURSING	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

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E 000	Initial Comments A Recertification, Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification from 10/12/21 through 10/15/21. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of Virginia Department of Health - Office of Licensure and Certification. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. On 10/13/21 at 9:19 PM, the Administrator was notified that the failure to ensure that staff properly disinfected the multiuse glucometers after performing accuchecks and between resident use constituted immediate jeopardy at F880-K: Infection Control. The immediate jeopardy began on 10/12/21 at 4:21 PM when Licensed Practical Nurse (LPN) 1 was observed to clean a multi-use glucometer with an alcohol pad. The removal plan for F880-K included: 1. An update of the Glucometer - Disinfection Policy, completed on 10/15/21; 2. Each resident requiring blood glucose monitoring was assigned a single-use glucometer; 3. All current facility licensed nursing staff completed training by 10/15/21; 4. Licensed nursing staff, including agency staff, will receive education and skills validation starting 10/13/21 on glucometer cleaning and disinfection per policy and	F 000		

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

Electronically Signed | 11/22/2021

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F 000	Continued From page 1 manufacturer's instructions and per the EPA approved disinfectant's instructions 5. Facility will ensure competency of agency staff through a combination of: 1:1 education by the Staff Development coordinator (SDC) or designee, bulletin notices in the electronic medical record (EMR), assigned orders in the EMR which will require nurses signature prior to accuchecks, and education sign off sheet in narcotics book to be completed at shift change during the medication cart handoff for any nurse not previously educated prior to nurse completing any glucometer procedure; 6. DON or designee will observe and validate proper glucometer cleaning and disinfection technique of two nurses on staff per shift for four weeks. The survey team validated the immediate jeopardy was removed on 10/15/21 at 8:20 PM following the facility's implementation of the removal plan. The deficient practice remained at a lower scope and severity of an "E" (pattern of potential for more than minimal harm) after the removal of the immediate jeopardy. Survey Dates: 10/12/21 to 10/15/21 Survey Census: 83 Sample Size: 21 Supplemental Residents: 12	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and	F 583		11/23/21

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F 583	Continued From page 2 confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure that one resident's (Resident (R) 233) out of a sample of 21 residents electronic medical record (EMR) was kept from public view.	F 583	1. Resident #233 information was secured immediately. 2. All residents have the potential to be affected by this practice. 3. Licensed and certified staff will be educated on resident personal and clinical	

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F 583	Continued From page 3 Findings include: Review of the facility's undated policy titled "Confidentiality" directs that the facility "complies with all the requirements of the Health Insurance Portability and Accountability Act (HIPPA) ... All information regarding residents is confidential ... a resident's personal or medical matters should never be discussed with other residents, visitors or anyone else ... " During an observation on 10/13/21 at 11:55 AM, the computer on Unit 1 East Hall was open on an unattended medication cart to R233's EMR. During this observation, multiple staff and two residents walked by the medication cart while R233's medical information was available for staff and residents to view. During an interview on 10/13/21 at 12:00 PM, Registered Nurse (RN) 2 acknowledged that the computer was open with R233's EMR on the screen when she left the medication cart to speak to a physician. During an interview on 10/15/21 at 8:05 PM, the Director of Nursing (DON) stated that during medication pass, staff are required to lock the computer to protect a resident's health information in the EMR when they leave the medication cart unattended.	F 583	information being kept confidential as well as HIPPA compliance. The HIPPA policy was reviewed-no changes were necessary. 4. Visual monitoring and observations by DON, Administrator, Staff Development Coordinator, Unit Managers or designee(s) will be conducted for compliance. Audits will be completed 3 X weekly for 4 weeks to assure compliance. Any violations in practice will be corrected immediately. Results of audits will be presented to the QAPI committee for oversight and any additional recommendations.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and	F 584		11/23/21

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F 584	Continued From page 4 supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility policies and procedures, the facility failed	F 584	1. All identified areas will be addressed and repaired by 11/22/2021.	

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F 584	Continued From page 5 to ensure a safe and clean environment in 10 of 16 resident rooms on the second-floor east unit. This deficient practice affected 19 of 30 residents on the second-floor east unit. Findings include: Observations on 10/12/21 at 9:05 AM, revealed in resident room (RR)231 large scrapes on the wall, one foot off the floor measuring 2 feet wide high by 1 foot high. Interview with the Assistant Maintenance Director acting as Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall. Observations on 10/12/21 at 9:10 AM, revealed in RR230 large scrapes on the wall one foot off the ground measuring 2 feet long by 1 foot high. Interview with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall. Observations on 10/12/21 at 9:15 AM, revealed in RR226 large scrapes on the wall, one foot off the floor measuring 2 feet long by 1 foot high. Interview with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall. Observations on 10/12/21 at 9:20 AM, revealed in RR223 large scrapes on the wall one foot off the ground measuring 3 feet long by 1 foot high. Interview with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall. Observations on 10/12/21 at 9:22 AM, revealed in RR224 large scrapes on the wall one foot off the ground and 2 feet long by 1 foot high. Interview	F 584	2. All residents have the potential to be affected by this practice. 3. Staff in all departments will be educated on how to access the TELS system for repair requests. Information for the TELS system will be posted at each time clock for staff information. 4. Environmental rounds will be conducted 5 x weekly for 4 weeks by maintenance staff, Administrator and/or designee to identify any needed repairs. Any identified safety issues will be repaired/corrected immediately. Minor issues will be prioritized and placed on a timeline for repair. Results of audits will be presented to the QAPI committee for oversight and any additional recommendations.	

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F 584	Continued From page 6	F 584		

with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall.

Observations on 10/12/21 at 9:28 AM, revealed in RR219 large scrapes on the wall, one foot off the ground, 3 feet long by 1 foot high. Drywall dust and paper debris from the scrape was observed on the floor. Interview with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall.

Observations on 10/12/21 at 9:29 AM revealed in RR218 large scrapes on the wall one foot off the floor measuring 2 feet long by 1 foot high. Interview with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall.

Observations on 10/12/21 at 9:30 AM, revealed in RR221 large scrapes on the wall one foot off the floor and measuring 2 feet long by 1 foot high. Interview with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall.

Observations on 10/12/21 at 9:30 AM, revealed in RR222 large scrapes on the wall, one foot off the floor measuring 3 feet long by 1 foot high. Interview with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall.

Observations on 10/12/21 at 9:35 AM, revealed in RR216 large scrapes on the wall, one foot off the floor to the left of the entrance to the room measuring 2 feet long by 1 foot high. Interview with the acting Maintenance Director on 10/15/21 at 11:00 AM verified the condition of the wall.

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F 584	Continued From page 7 Interview with the acting Maintenance Director on 10/15/21 at 6:30 PM revealed "we have plans to update the rooms but have not acted on the plans recently." Interview with the Administrator on 10/15/21 at 10:00 PM revealed "we don't really have policy; we follow the guidelines for using Tels [maintenance communication and logging system] for submitting a work order."	F 584		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 605		11/23/21

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F 605	Continued From page 8 symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to ensure one resident (Resident (R) 16) of 21 sampled residents was free from chemical restraints. On 07/16/21 R16 was administered Ativan (an antianxiety medication) via intramuscular (IM) injection for staff convenience. Findings include: Review of the facility's policy titled "Resident Rights," dated 11/01/20, revealed " ... The resident has a right to be treated with respect and dignity, including a. The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms ..." Review of the facility's policy titled, "Restraint Free Environment," revised 10/28/20, revealed "Policy: Each resident shall attain and maintain his/her highest practical well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints ... 2. Chemical restraint is defined as any medication that is used for discipline or convenience and not required to treat medical symptoms ..."	F 605	1. The Ativan order for Resident #16 was discontinued on 7/21/2021. 2. All residents with orders for psychotropic drug usage are at risk from this practice. 3. MD or NP will review psychotropic drug orders weekly for appropriate use and GDR if indicated. Licensed clinical staff will be educated on appropriate usage of psychotropic drugs as well as non pharmacological interventions. 4. The Pharmacist will review psychotropic drug usage weekly X 4 weeks for any contraindications or need to initiate GDR. Results of audit will be presented to the QAPI committee for oversight and any additional recommendations.	

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F 605	Continued From page 9	F 605		

Review of R16's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed R16 was admitted to the facility on 10/24/19 with diagnoses which included patient's noncompliance with other medical treatment and regimen, procedure and treatment not carried out because of patient's decision for other reasons, and generalized anxiety disorder.

Review of R16's "Medication Administration Record (MAR)," dated July 2021, located in the EMR under the "Orders" tab, revealed on 07/16/21, Licensed Practical Nurse (LPN) 8 administered R16 "Lorazepam [Ativan] Solution 2MG/ML Inject 1 ml intramuscularly every 8 hours as needed for Extreme agitation, anxiety ..."

Review of R16's "Progress Notes," dated 07/16/21, located in the EMR under the "Progress Notes" tab, revealed "pt [patient] is alert and violent [sic] pt care was being given, pt allowed staff to remove brief when pt was assisted to roll on to back pt hit nurse in face causing nurse forehead to bleed, [sic] pt was given PRN [as needed] Ativan per order ..."

Interview on 10/15/21 at 12:10 PM with LPN8, revealed she administered the PRN Ativan to R16 because his sheets were still saturated with urine, his brief was off exposing his wound, and this was the only way they [staff] could get him dressed. LPN8 stated she was not allowed to let him sit in urine. Continued interview with LPN8 revealed it was her understanding that the PRN Ativan was to be administered to calm R16 down so they could change him and them [staff] not get hit. LPN8 stated she did consider the Ativan a chemical restraint; however, her supervisor [the

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F 605	Continued From page 10 DON] told her that R16 did not have the right to refuse treatment because he did not have the capacity to refuse decisions. LPN8 also stated R16 did not have the ability to independently get up out of bed and that he could not physically attack her if she backed away from him. Interview on 10/15/21 at 1:53 PM with Family Nurse Practitioner (FNP) 1 revealed the PRN Ativan should not have been administered to R16 because that was considered a pharmacological restraint. FNP1 stated the resident should have been left alone to calm down. Interview on 10/15/21 at 4:33 PM with FNP2 revealed she was the provider who wrote the order for the PRN Ativan for the purpose of reducing his anxiety. FNP2 stated the Ativan should have been used to treat R16's medical symptoms and not for staff convenience. FNP2 also stated when the PRN Ativan was used for staff convenience, it was considered a chemical restraint. The FNP further stated just for staff to be able to finish resident care would not be a reason to give him an IM injection of Ativan. During an interview on 10/15/21 at 8:13 PM, the Director of Nursing (DON) stated that the use of the IM injection of Ativan was not a chemical restraint. The DON stated, "I don't want him [R16] sitting in urine and stool."	F 605		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's	F 636		11/23/21

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functional capacity.

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the

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F 636	Continued From page 12 timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to complete an initial nursing assessment upon admission for one resident (Resident (R) 290) out of 21 sampled residents. Findings include: Review of the "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab revealed that R290 was admitted on 10/01/21 for skilled care services for fracture of the left femur. Additional diagnoses included insomnia, pain, major depressive disorder, essential (primary) hypertension (high blood pressure), osteoporosis (condition where bones become weak and brittle) and atherosclerotic heart disease (a buildup of fats and cholesterol in the artery walls). Review of R290's admission "Minimum Data Set (MDS") with an Assessment Reference Date (ARD) of 10/08/21 revealed a "Brief Interview for	F 636	1. An Admission Assessment was completed for Resident #290 on 10/14/2021. 2. All new admissions and readmissions have the potential to be affected by this practice. 3. Licensed staff will be educated on the admission process to include timeliness of completion of the admission assessment. 4. The DON or designee will audit 100% of all new admissions or readmissions x 4 weeks to assure timeliness and completion of the admission assessment. Results of these audits will be presented to the QAPI committee for oversight and any additional recommendations.	

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Mental Status (BIMS") score of 15 out of 15, indicating that R290 was cognitively intact.

Review of R290's "Admission" documents, located in the EMR under the "Assessments" tab, revealed that a nursing assessment was not completed upon admission to the facility.

During an interview on 10/12/21 at 10:35 AM, R290 indicated that she did not remember anyone discussing her care needs upon her arrival to the facility.

During an interview on 10/14/21 at 1:14 PM, the Director of Nursing (DON) indicated that her expectation was that the nurse admitting the resident completes the admission assessment upon arrival to facility and that it is her (DON) responsibility to ensure the assessment was completed. During this interview, the DON confirmed that R290's admission assessment was not completed upon admission to the facility.

During an interview on 10/14/21 at 9:30 AM, the Medial Director indicated that his expectation was that a nursing assessment would be completed when a resident is admitted upon arrival or at least the next day.

During an interview on 10/14/21 at 1:40 PM, the Administrator indicated that his expectation was that nursing admission assessments are done upon admission to facility.

During an interview on 10/15/21 at approximately 3:36 PM, the Corporate Registered Nurse, Director of Clinical Services, (Corporate RN) indicated that the expectation was that a complete nursing assessment would be done

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F 636	Continued From page 14 upon admission by the admitting nurse, within 24 hours. The Corporate RN verified that the facility does not have a policy for nursing assessments.	F 636		
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 record review, interview, and review of the "Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual," the facility failed to ensure the accuracy of a "Minimum Data Set (MDS)" assessment for restorative nursing services for one resident (Resident (R) 76) in a total sample of 21 residents. Findings include: Review of the facility's policy titled "Assessment Frequency/Timeliness," dated 11/01/20 and revised on 10/01/21, directs "The purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI [Resident Assessment Instrument] Manual . . . " Review of the "Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual" Chapter 3 "MDS" Items [O] documented that "Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs ... Review the resident's medical record to determine	F 641	1. The comprehensive assessment for Resident #76 dated 9/23/2021 was reviewed for necessary corrections. None required. 2. All residents receiving restorative services are at risk if the MDS does not accurately reflect those services. 3. MDS staff were educated 11/22/2021 regarding accuracy of assessments to include restorative services. 4. The Regional Director of Reimbursement will monitor 10% of facility resident receiving restorative services weekly x 4 weeks to assure the MDS is coded accurately. Results of these audits will be presented to the QAPI committee for oversight and any additional recommendations.	11/23/21

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whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days ... Restorative nursing program refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning. A resident may be started on a restorative nursing program when he or she is admitted to the facility with restorative needs, but is not a candidate for formalized rehabilitation therapy, or when restorative needs arise during the course of a longer-term stay, or in conjunction with formalized rehabilitation therapy. Generally, restorative nursing programs are initiated when a resident is discharged from formalized physical, occupational, or speech rehabilitation therapy."
Review of R76's "Profile" located in the electronic medical record (EMR) revealed R76 was admitted to the facility on 02/12/20 and readmitted on 03/01/20 for long term care.

Review of active physician orders in the "Orders" tab of the EMR and dated 07/07/21, revealed R76 required bilateral palm guards at all times, except when bathing and passive range of motion (PROM) exercise. Review of the physician's orders revealed R76 was to receive bilateral upper extremity range of motion (ROM) exercises 5-6 times per week for contracture management. Further review of the physician's orders revealed an order, dated 09/23/21, for a hip abduction (positioned away from the midline of the body) brace to be in place for four hours per day.

Review R76's active "Care Plan," initiated on 08/13/20 and located in the EMR under the "Care

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Plan" tab, revealed a care plan for a Level II Preadmission Screening and Resident Review (PASRR) related to Intellectual Disabilities with planned interventions to provide appropriate durable medical equipment (DME) as needed . . . , and provide occupational, physical, speech therapy, and restorative nursing as needed. The "Care Plan" also indicated R76 had an alteration in musculoskeletal status related to bilateral upper extremity contractures (fixed shortening of muscle or tendon resulting in joint deformity) initiated on 04/10/20 with planned interventions to apply right and left palmar guards per therapy recommendation.

Review of R76's annual "MDS" with an Assessment Reference Date (ARD) of 09/23/21 revealed R76 does not speak and the staff assessment for R76's mental status indicated she had severe cognitive impairment. R76 was totally dependent on staff for all activities of daily living (ADL) including bed mobility, positioning, and transfer. R76 had impairment of range of motion in her bilateral upper and lower extremities (both arms, hands, legs, and feet); however, no Restorative Nursing Services, specifically range of motion and splint or brace usage, was noted on this "MDS" for R76 despite physician's orders and care plans in place for ROM, restorative nursing services, and usage of splints/braces.

During an interview on 10/15/21 at 2:55 PM, the MDS Registered Nurse (RN) verified that R76's "MDS" with an ARD of 09/23/21 did not code the restorative nursing program. The MDS RN stated that this "MDS" was not coded for restorative nursing because the facility did not have any restorative nursing aides.

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F 641	Continued From page 17 During an interview on 10/15/21 at 3:37 PM, the Corporate RN stated that ROM therapy is part of routine care of a resident, and the Certified Nursing Assistants CNA's and nurses were able to perform that task. When asked if a resident had a physician order for restorative nursing services and discharge recommendations from therapy for restorative nursing recommendations, should Section O of the MDS code the resident for restorative nursing services, the Corporate RN replied "yes." Cross Reference: F688-Increase/prevent Decrease in ROM/mobility.	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a	F 655		11/23/21

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F 655	Continued From page 18 comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and policy review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours of admission to the facility for five residents (Resident (R)286, R288, R290, R23, and R233) out of a total sample of 21 residents. Findings include: Review of facility policy titled, "Baseline Care Plan," dated 10/01/21, revealed, "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care for the resident that meets professional standards of quality care ... The baseline care plan will: a. Be developed within 48 hours of a	F 655	1. A baseline care plan was completed for Resident #286 on 10/14/2021, Resident #288 on 9/30/2021, Resident #290 on 10/13/2021, Resident # 23 on 10/15/2021 and Resident #233 on 10/14/2021. 2. All new and readmitted residents are at risk if a baseline care plan is not initiated. 3. Licensed clinical staff will be educated by 11/23/2021 on the admissions process to include creating a baseline care plan. 4. 100% of all new admissions will be audited weekly x 4 weeks by the DON or designee to assure base line care plans have been initiated within 48 hours of admission. Results of the audits will be presented to the QAPI committee for	

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F 655	Continued From page 19 resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders. iv. Therapy services. v. Social Services. vi. PASRR recommendation, if applicable. 2. The admitting nurse, or supervising nurse on duty, shall gather information from the admission physical assessment, hospital transfer information, physician orders, and discussion with the resident and resident representative, if applicable. a. Once gathered, initial goals shall be established that reflect the resident's stated goals and objectives. b. Interventions shall be initiated that address the resident's current needs including: i. Any health and safety concerns to prevent decline or injury, such as elopement, fall, or pressure injury risk. ii. Any identified needs for supervision, behavioral interventions, and assistance with activities of daily living. iii. Any special needs such as for IV therapy, dialysis, or wound care . . . 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 4. A written summary of the baseline care pan shall be provided to the resident and representative in a language that the resident/representative can understand . . . " 1. Review of R286's "Face Sheet" found in the Electronic Medical Record (EMR) under the "Profile" tab revealed that R286 was admitted on 10/08/21 for skilled services to address cognitive communication deficits. Additional diagnoses included atrial fibrillation (irregular, rapid heartbeat), glaucoma (loss of vision causes by optic nerve damage), diverticulitis (inflammation of the intestine), anxiety disorder, osteoporosis (condition where bones become weak and brittle) and use of a foley catheter. R286 was placed on	F 655	oversight and any additional recommendations.	

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advanced droplet precautions upon admission as a new admission due to a recent history of coronavirus disease (COVID-19) and unvaccinated status.

Review of R286's admission "Minimum Data Set (MDS)" with Assessment Reference Date (ARD) date of 10/14/21 indicated "in progress."

Review of R286's "Admission/readmission Data Collection," dated 10/08/21, found in the EMR under the "Assessment" tab indicated that R286 was oriented to "person."

Review of R286's "Care Plan" found in the EMR under the "Care Plan" tab revealed a care plan initiated on 10/11/21, not within 48 hours of admission.

2. Review of R288's "Face Sheet" found in the EMR under the "Profile" tab indicated that R288 was admitted on 09/30/21 with a foley catheter and a diagnosis of diverticulitis (inflammation of the intestines), perforation (a hole that develops through the wall of a body organ) and peritonitis (inflammation of the membrane that lines the abdominal wall), exploratory laparoscopy (a type of surgery that allows the surgeon to explore inside the abdomen with a small incision), sigmoid resection (surgical removal of the bottom section of the colon), colostomy (a surgical procedure in which a piece of the colon is diverted through the abdominal wall) and exacerbation of chronic obstructive pulmonary disease (COPD).

Review of the admission "MDS" with ARD date of 10/07/21 revealed a "Brief Interview for Mental Status (BIMS)" score of 10 out of 15, indicating

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that R288 was moderately impaired.

During an interview on 10/13/21 on at 9:05 AM, the Director of Nursing (DON) confirmed that a resident centered baseline care plan was not completed for R288.

Review of R288's "Care Plan" found in the EMR under the "Care Plan" tab revealed a care plan initiated on 10/05/21 not within 48 hours of admission.

3. Review of the "Face Sheet" located in EMR under the "Profile" tab revealed that R290 was admitted on 10/01/21 for skilled care services for fracture of her left femur (thigh bone). Additional diagnoses included insomnia (inability to stay asleep), pain, major depressive disorder, essential (primary) hypertension, osteoporosis (condition when bones become weak and brittle) and atherosclerotic heart disease (buildup of fats in and on the artery walls).

Review of R290's admission "MDS" with and ARD of 10/08/21 revealed a "BIMS" score of 15 out of 15, indicating that R290 was cognitively intact.

During an interview on 10/12/21 at 10:35 AM, R290 indicated that she did not know anything about a care plan and wasn't sure what it was.

During an interview on 10/14/21 at 8:39 AM, the DON indicated that a Baseline Care plan should be completed for each admitted resident within 48 hours of admission and that the admitting nurse is responsible to do it as part of the admission process. The DON further indicated that she and/or the MDS Coordinator were responsible to ensure the baseline care plan was completed.

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During this interview, the DON confirmed that a baseline care plan was not developed for R286, R288, or R290 within 48 hours of admission.

During an interview on 10/13/21 at 8:48 AM, Family Nurse Practitioner (FNP) indicated that her expectation was that a resident centered baseline care plan be developed within 48 hours of admission and incorporates diagnoses, medications, and interventions that meet the residents care needs.

During an interview on 10/14/21 at 1:40 PM, the Administrator indicated that it was his expectation that baseline care plans are completed upon admission to facility, or at the very least the next day.

During an interview on 10/15/21 at 3:36 PM, Corporate Registered Nurse (Corporate RN) Director of Clinical Services indicated that the expectation was that a resident centered baseline care plan is established within 48 hours of admission to the facility.

4. Review of R23's undated "Admission Record," located in the resident's electronic medical record (EMR) revealed the resident was admitted to the facility on 08/04/21 with diagnoses which included nontraumatic intracerebral hemorrhage (stroke), acute kidney failure, hemiplegia and hemiparesis (weakness and paralysis), and hypertensive (high blood pressure) emergency.

Review of R23's entire EMR revealed no documented evidence that a baseline care plan was completed within 48 hours of the resident's admission.

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F 655	Continued From page 23 5. Review of R233's undated "Admission Record," located in the resident's EMR under the "Profile" tab, revealed the resident was admitted to the facility on 09/24/21 with diagnoses which included chronic kidney disease stage 4, type 2 diabetes mellitus without complications, and presence of cardiac pacemaker. Review of R233's entire EMR revealed no documented evidence that a baseline care plan was completed within 48 hours of the resident's admission. During an interview on 10/15/21 at 3:35 PM, the Regional Director of Clinical Services (RDCS) confirmed no baseline care plan had been completed for R23 or R233 until today. The RDCS stated it was her expectation the baseline care plans would have been completed within 48 hours of admission.	F 655		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and policy review, the facility failed to ensure that	F 679	1. Resident #76 activity preferences were updated and added to the care plan	11/23/21

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F 679	Continued From page 24 one resident (Resident (R) 76) of three residents reviewed for activities out of a total sample of 21 residents was consistently provided activities that supported the physical, mental, and psychosocial needs of the resident. Findings include: Review of the facility's policy titled "Activities," dated 11/01/20, revealed "It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility-sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychological well-being of each resident, as well as encourage both independence and interaction within the community ... Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs." Review of R76's "Profile" located in the electronic medical record (EMR) revealed R76 was admitted to the facility on 02/12/20 and readmitted on 03/01/20 for long term care. Review of an annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/23/21 revealed R76 did not speak and had severe cognitive impairment. Review of the staff preferences for daily activities included listening to music, doing things with groups of people, participating in favorite activities, spending time outdoors, and participating in religious activities. Review of R76's active "Care Plan," located in the	F 679	on 11/18/2021. 2. All residents who are dependent on staff for recreation needs or are unable to communicate their daily preferences are at risk from this practice. 3. Activity staff to receive education on documentation of activities provided for the residents. Activities provided will be documented in the electronic health record. 4. Administrator or designee will audit 10% of residents with impaired cognitive function for documented participation in activities weekly x 4 weeks and then as needed thereafter. Results of the audits will be presented to the QAPI committee for oversight and any additional recommendations.	

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EMR and initiated on 10/04/21, revealed that R76 had impaired cognitive function/dementia or impaired thought processes, therefore staff were to anticipate and meet the resident's needs and "engage [her] in simple, structured activities like movies, music, etc." Further review of the "Care Plan" revealed on 10/06/21 a care plan was initiated stating that R76 "is dependent on staff for activities, cognitive stimulation, social interaction related to cognitive deficits, immobility, and physical limitations with planned interventions to ensure TV is on for sensory stimulation, 1 to 1 bedside/in-room visits and activities if unable to attend out of room events, and music visits for sensory stimulation."

Review of "Activities" report/logs, dated from 08/17/21 to 10/15/21 and provided by the Administrator from the EMR, revealed that R76 participated in two group activities and no one-on-one activities during the two months reviewed.

Observations on 10/12/21 at 9:40 AM, 12:30 PM and 3:30 PM, on 10/13/21 at 8:50 AM, 2:00 PM and 8:25 PM; and on 10/14/21 at 10:00 AM revealed R76 was in bed with no music or television on for stimulation. Random observations during the survey revealed R76 was not in the Unit 2 dining/activity room during scheduled and/or nonscheduled activities.

During an interview on 10/15/21 at 9:36 AM, the Activities Director stated that R76 is nonverbal and "we just read to her and stuff like that." During the interview, the Activities Director was unable to explain why R76 was not included in the activities observed during the survey.

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F 679	Continued From page 26 During an interview on 10/15/21 at 9:32 PM, the Administrator acknowledged that the activity participation for R76 was not present in the Activity Logs provided to the surveyor.	F 679		
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, record review, interview, and policy review, the facility failed to ensure that one resident (Resident (R) 76) of two residents reviewed for position and mobility out of a total sample of 21 residents received treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, facility staff failed to provide physician ordered passive (PROM) and splints and/or braces as recommended by therapy.	F 688	1. The splint was applied to Resident #76 and she received range of motion. 2. All current residents with orders for splints and/or braces are at risk from this practice. 3. All current and future residents will be screened by therapy personnel for decreased ROM and mobility. All direct care staff will be educated on ways to increase ROM and/or prevent further decrease in ROM in residents with splints	11/23/21

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F 688	Continued From page 27 Findings include: Review of the facility's policy titled "Restorative Nursing Program," dated 11/01/20, revealed "all residents will receive maintenance restorative nursing services ... by certified nursing assistants ... Residents, as identified during the comprehensive assessment process, will receive services from restorative aides when they are assesses to have a need for such services (level II services). These services may include a. Passive or active range of motion. b. Splint or brace assistance ... Potential candidates for Level II restorative nursing services may be identified through one or more of the following processes: a. Physical assessment b. MDS [Minimum Data Set] assessments c. specialized rehabilitation assessments" Review of R76's "Profile" located in the electronic medical record (EMR) revealed R76 was admitted to the facility on 02/12/20 and readmitted on 03/01/20 for long term care. Review of R76's annual "MDS" with an Assessment Reference Date (ARD) of 09/23/21 revealed R76 was nonverbal and had severe cognitive impairment. In addition, this "MDS" documented that R76 was totally dependent on staff for all activities of daily living (ADLs) including bed mobility, positioning, and transfer. Further review of this "MDS" revealed R76 had impairment in range of motion in her bilateral upper and lower extremities (both hands, arms, feet, and legs). Review R76's active "Care Plan," initiated on 08/13/20 and located in the EMR under the "Care Plan" tab, revealed a care plan with planned	F 688	and braces. All orders for braces, splints, or ROM will be place on the CNA's Kardex. 4. Unit Manager or designee will audit 10% of resident's Point Click Care documentation and application of splints, braces, passive ROM provided for compliance weekly X 4 weeks. Results of these audits will be presented to the QAPI committee for oversight and any additional recommendations.	

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interventions to "provide appropriate durable medical equipment (DME) as needed . . . and provide occupational, physical, speech therapy, and restorative nursing as needed." Further review of the care plans revealed a care plan for alteration in musculoskeletal status related to bilateral upper extremity contractures (fixed shortening of muscle or tendon resulting in joint deformity), initiated on 04/10/20, with planned interventions to apply right and left palmar (palm of hands) guards per therapy recommendation. The Care Plan did not contain specific problems and recommendations for the bilateral lower extremities.

Review of active physician orders in the "Orders" tab, located in the EMR and dated 07/07/21, revealed an order for bilateral palm guards at all times, except when bathing and during passive range of motion (PROM) exercise. Review of the physician's orders revealed R76 was to receive bilateral upper extremity range of motion (ROM) exercises 5-6 times per week for contracture management Further review of the physician's orders revealed an order, dated 09/23/21, for a hip abduction (positioned away from the midline of the body) brace to be in place for four hours per day.

Review of the undated "Visual Bedside Kardex Report" located in the Kardex section under the "Care Plan" tab in the EMR, revealed no instruction for ROM or the use of splints and/or braces for resident care.

Review of a Physical Therapy (PT) Evaluation, dated 01/28/21 and provided by the Physical Therapist (PT) 1, revealed that R76 presented with decreased ROM of her bilateral lower

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extremities (BLEs) and contractures of bilateral knees and bilateral hips that required skilled services to improve ROM. Further review of this PT evaluation revealed "Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: muscle atrophy [wasting of muscle], pain."

Review of the PT discharge summary, dated 03/17/21, revealed R76 received passive stretching (someone else stretching the muscle) of the bilateral hamstrings (muscle of the backs of thighs), hips adductors (muscles of the hips) and quadriceps (muscles of the front of thighs) to decrease contractions, PROM to bilateral knees to improve mobility and positioning, and donning and doffing (putting on and taking off) of abductors wedges for three hours. R76 was discharged from PT with recommendations for caregivers to use the abduction wedge for three hours per day.

Review of the PT Discharge Summary for dates of service of 08/25/21 to 09/23/21 and provided by PT1, revealed the short-term goal was for R76 to improve right hip extension and bilateral knee extension to improve positioning and decrease pain during ADLs with caregivers. Review of this discharge summary revealed that caregivers, by 09/21/21, demonstrated proper donning/ doffing of leg brace to decrease risk for future contractions. Discharge recommendations included the use of a splint /brace and home exercise program.

During an observation on 10/14/21 at 10:03 AM, Certified Nursing Assistant (CNA) 2 and CNA 3 provided personal care for R76. R76 was in bed

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and had both of her legs bent and contracted toward her body; there was no wedge or pillow used between her legs for positioning and the resident's knees were touching each other. CNA2 did not perform any PROM to the lower extremities and when she was done with the task, she did not use a wedge or any pillow between the resident's legs and R76 remained contracted with her knees bent and legs towards her body and her knees remained touching each other.

During an interview on 10/14/21 at 10:25 AM during the observation, CNA2 stated that she had never provided care to R76 before and that she got information from the staff and the CNA Kardex on how to care for the resident. CNA2 stated while performing hygiene, R76 was resistive to normal movement, and was "tight" so she (CNA2) did what she could without causing the resident discomfort. CNA2 acknowledged that she did not perform any PROM and positioned the resident in the same manner that she found her.

During an interview on 10/14/21 at 2:13 PM, PT1 stated that R76 was discharged from PT services on 09/23/21 with an abductor brace for her knees that she should wear for four hours per day; this was a continuation of an ongoing recommendation for the use of the abductor brace for "quite some time." PT1 stated that therapy had made prior recommendations for bilateral lower extremity (BLE) ROM when the facility had restorative aides; however, when she was discharged from services in September 2021 the facility no longer had restorative CNA's, thus no ROM for her lower extremities was recommended. PT1 stated without the use of the wedge, R76's contractures would increase. PT1

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stated the floor staff should be applying all of R76's braces and that if they do not know how to apply them, they should reach out to therapy staff for assistance.

Review of an "Occupational Therapy (OT) Evaluation and Treatment Plan," dated 01/21/21, revealed R76 had impaired right and left upper extremity range of motion and was dependent on staff for ADL's due to cognitive status. Further review of this OT plan revealed that the Restorative CNA (RCNA) was to provide PROM exercise to bilateral upper extremities prior to splint application and to continue application of right palm guard and left finger/ wrist extension splint. This OT evaluation and treatment plan indicated that the restorative nursing program was appropriate for the management of the resident contractures of the bilateral upper extremities.

Review of the "Occupation Therapy (OT) Discharge Summary" for dates of service 05/17/21 to 07/07/21 and provided by PT1 revealed R76 was discharged from skilled services with recommendations for caregivers to provide a PROM exercise program.

Observations on 10/12/21 at 9:40 AM and 3:30 PM, and on 10/13/21 at 8:50 AM and 8:25 PM revealed R76 was sleeping in bed with her arms contracted toward her body and her hands contracted with no splints in place.

During an observation on 10/14/21 at 10:03 AM, CNA2 and CNA3 provided personal care for R76. R76 was in bed and had both of her arms were contracted toward her body with her hands/fists contracted. During the care, CNA2 washed R76's

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bilateral arms and both of her hands, including the palms and fingers without performing any range of motion. During these tasks CNA2 could minimally move R76's upper extremities and hands due to the contractures. When CNA2 was done with the task, she did not apply the hand splint and palm guards that were located on top of R76's dresser.

During an interview on 10/14/21 at 10:25 AM during the observation, CNA2 acknowledged that she did not perform any ROM and apply splints because she was unaware if the resident required those services.

Review of the "RESTORATIVE: Passive Range of Motion to BLE for further contracture prevention" in the "Tasks" tab (CNA documentation) in the EMR revealed no data for the last 30 days.

Review of the "RESTORATIVE: Splint or Brace (specify) documentation in the Tasks" tab in the EMR revealed no data for the last 30 days.

During an interview on 10/14/21 at 2:15 PM, the Occupation Therapist (OT)1 stated R76 was discharged from OT services on 07/07/21 and required the use of a splint/brace for her bilateral upper extremities (BUE) and BUE PROM exercise daily. OT1 stated that for a very contracted resident like R76, if the resident did not receive the services she would be at risk for poor personal hygiene, potential skin breakdown, sores, edema, swelling, and pain.

During an observation of R76 on 10/15/21 at 9:22 AM, the Director of Nursing (DON) acknowledged that R76 was in bed without the use of brace/splints and wedges and stated that the

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F 688	Continued From page 33 brace/splints and wedges were placed on and off every morning by therapy staff. When informed that therapy staff stated that nursing staff are performing the task, the DON replied that, "they [therapy staff] will have to come up every day and train the staff because I have a new CNA practically every day up here." During an interview on 10/15/21 at 3:37 PM, the Corporate Registered Nurse (RN) stated that ROM therapy is part of routine care of a resident and the CNAs, and nurses were able and should perform ROM services.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and policy review, the facility failed to ensure that one resident (Resident (R) 15) out of five residents reviewed for accidents was transported in a wheelchair with legrests to prevent injury in a total sample of 21 residents. Findings include: Review of the facility's policy titled "Accidents and Supervision," dated 11/01/20, directs "The facility shall establish and utilize a systemic approach to	F 689	1. The leg rests for Resident #15 wheelchair were applied immediately. 2. Residents that require leg rests on their wheelchair are at risk from this practice. Unit Managers will conduct a 100% review to assure all residents' needing leg rests on their chairs have them 3. Certified and licensed nursing staff will be educated on placement of leg rests on wheelchairs for those residents who require them. 4. DON or designee will audit 100% of	11/23/21

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F 689	Continued From page 34 address resident risk and environmental hazards to minimize the likelihood of accidents ...The facility will provide adequate supervision to prevent accidents ... based in the individual resident's assessed needs and identified hazards in the resident environment." Review of the R15's "Admission Record" located in the electronic medical record (EMR) revealed R15 was admitted to the facility on 06/10/21 and readmitted on 10/08/21. Review of the significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/06/21 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 indicating R15 was cognitively intact. Further review of this "MDS" revealed R15 required extensive staff assistance for locomotion on the unit. During an observation on 10/12/21 at 11:17 AM, Certified Nursing Assistant (CNA) 1 was observed near the nurses' station transporting R15 in a wheelchair without any footrests on the wheelchair. The Director of Nursing (DON) saw this and instructed CNA1 to get footrests for the wheelchair. At approximately 11:18 AM, CNA1 was observed transporting R15 via wheelchair without footrests down the hall to her room, approximately 94 feet away. During the transport R15's feet were observed intermittently touching the tiled floor increasing the risk of injury to R15's feet and/or legs. During an interview on 10/12/21 at 11:23 AM, CNA1 acknowledged that she did not use footrests to transport the resident. CNA1 stated that she needed to get the footrests for the	F 689	wheelchairs 3 X weekly x 4 weeks to assure leg rests are utilized if needed. Results of audits will be presented to the QAPI committee for oversight and any additional recommendations.	

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F 689	Continued From page 35 wheelchair and did not know if there were footrests for the wheelchair in the resident's room. During the interview CNA1 and the surveyor checked the resident's room, and no footrests were found. During an interview on 10/15/21 at 8:46 AM, the DON stated that R15 was weak and had just started receiving hospice services. The DON verified that R15 was not able to keep her feet elevated during wheelchair transport and required the use of footrests to prevent injury to her feet and/or legs.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		11/23/21

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F 758	Continued From page 36 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and review of the facility's policy, the facility failed to ensure one resident (Resident (R) 78) of seven residents reviewed for unnecessary medications had a stop date for a PRN (as needed) antianxiety medication used for seizures. Findings include: Review of the facility's policy titled, "Unnecessary Drugs-Without Adequate Indication for Use," dated 11/01/20, revealed "Policy: It is the facility's policy that each resident's drug regimen is	F 758	1. Resident # 78 order for prn diazepam was assigned a stop date by the nurse practitioner on 10/15/2021. 2. All residents receiving prn psychotropic medications are at risk if a stop date is not assigned. A 100% audit of prn psychotropic medication orders will be conducted to identify any other residents affected. Any identified omissions will be corrected immediately. 3. MD or NP will place a 14 day stop date on prn psychotropic medication orders. Licensed clinical staff will be educated on	

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F 758	Continued From page 37 managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being free from unnecessary drugs ... 2. The attending physician will assume leadership in medication management by developing, monitoring, and modifying the medication regimen ... Each resident's drug regimen will be reviewed on an ongoing basis, taking into consideration the following elements: ... b. Duration of use ...4. When a drug is initiated or used to treat an emergency situation (i.e., acute onset or exacerbation of symptoms or immediate threat to health or safety of resident or others): a. The acute treatment period will be limited to seven days or less: and b. A clinician in conjunction with the interdisciplinary team will evaluate and document the situation within 7 days ..." Review of R78's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab, revealed R78 was admitted to the facility on 04/16/21 and readmitted to the facility on 05/21/21 with diagnoses which included epilepsy (seizure activity). Review of R78's "Order Summary Report," located in the resident's EMR under the "Orders" tab, revealed an order dated 04/27/21 of "diazepam [antianxiety medication] gel 2.5 MG [milligram] insert 2.5 mg rectally ever 6 hours as needed for seizures give rectally for seizure lasting > [longer than] 2 mins [minutes]." Interview on 10/15/21 at 9:45 AM with the Medical Director revealed when asked about the PRN order for the diazepam, the Medical Director stated regulations were fine, but if the resident's	F 758	the need for stop dates to ensure order accuracy by compliance date. 4. The DON or designee will complete 100% audit of prn psychotropic medication orders weekly x 4 weeks to assure 14 day stop dates have been assigned to the prn psychotropic orders. Observed issues will be corrected immediately. Results of the audits will be presented to the QAPI committee for oversight and any additional recommendations.	

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F 758	Continued From page 38 safety was in danger, the PRN order with no stop date was appropriate and he would not expect the provider to put a stop date because the medication was for R78's seizures. Interview on 10/15/21 at 1:47 PM with Family Nurse Practitioner (FNP) 1 revealed she ordered the diazepam for R78's seizures. FNP1 stated she thought the requirement for the stop date was more for diazepam used for mental illness and therefor had not reevaluated R78 for continued use of diazepam. Review of an email from the Consultant Pharmacist to the facility dated 10/15/21 revealed the pharmacist wrote related to the PRN diazepam, " ... if it is a PRN used for seizures, it [no stop date] is ok ..." During an interview on 10/15/21 at 8:08 PM, the Director of Nursing (DON) stated that R78's PRN diazepam should have had a stop date and acknowledged she was aware of the regulation.	F 758		
F 880 SS=K	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	F 880		11/23/21

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F 880	Continued From page 39 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility 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.	F 880		

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F 880	Continued From page 40 §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, record review, interviews, policy review, review of the disinfectant label, review of manufacturer's guidelines, and review of Centers for Disease Control and Prevention (CDC) guidelines for COVID-19, the facility failed to: 1. ensure that three of four Licensed Practical Nurses (LPN) (LPN 1, LPN2, and LPN4) on Unit 2 cleaned and disinfected multi-use glucometers per the device manufacturer's instructions and per the EPA-approved disinfectant's instructions for use when performing fingerstick blood glucose testing (accuchecks) between residents; and 2. ensure that a new agency staff was screened for signs and symptoms of COVID-19 upon entrance to the facility. The failure to ensure the staff cleaned and disinfected multi-use glucometers per the device manufacturer's instructions and per the EPA-approved disinfectant's instructions for use when performing fingerstick blood glucose testing created a likelihood for the transmission of bacteria, viruses, and/or blood-borne pathogens between residents.	F 880	1. All residents were issued a single resident use glucometer on 10/13/2021. All multiuse glucometers, lancets and gauzes were discarded on 10/13/2021 and the baskets were disinfected. CNA #1 was immediately rapid tested on 10/12/2021 for Covid-19 with negative results. 2. All residents utilizing blood glucose monitoring devices are at risk from this practice. All residents are at risk if staff screening for Covid-19 symptoms are not followed. 3. All residents were assigned individual use blood glucose monitoring devices. All licensed clinical staff (including agency) were educated on individual BGM devices and proper cleaning per manufacturer instructions. All new nursing staff will be trained prior to taking an assignment on procedures. All new staff in the building to be educated prior to working in building about temping/logging in requirements by compliance date.	

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F 880	Continued From page 41 Findings include: On 10/13/21 at 9:19 PM, the Administrator was notified that the failure to ensure that staff properly disinfected the multiuse glucometers before and after resident use constituted immediate jeopardy at F880-K: Infection Control. The facility provided an acceptable plan for removal of the immediate jeopardy on 10/15/21 at 3:38 PM. The removal plan for F880-K included: 1. An update of the Glucometer - Disinfection Policy, completed on 10/15/21; 2. Each resident requiring blood glucose monitoring was assigned a single-use glucometer; 3. All current facility licensed nursing staff completed training by 10/15/21; 4. Licensed nursing staff, including agency staff, will receive education and skills validation starting 10/13/21 on glucometer cleaning and disinfection per policy and manufacturer's instructions and per the EPA approved disinfectant's instructions 5. Facility will ensure competency of agency staff through a combination of: 1:1 education by the Staff Development coordinator (SDC) or designee, bulletin notices in the electronic medical record (EMR), assigned orders in the EMR which will require nurses' signature prior to accuchecks, and education sign off sheet in narcotics book to be completed at shift change during the medication cart handoff for any nurse not previously educated prior to nurse completing any glucometer procedure; 6. Director of Nursing (DON) or designee will observe and validate proper glucometer cleaning and disinfection technique of two nurses on staff per shift for four weeks.	F 880	4. DON or designee will observe and validate proper glucometer cleaning and disinfection technique of 2 nurses on staff per shift x 4 weeks. Administrator or designee will audit logs 3 times weekly x 4 weeks to ensure staff compliance with temping/logging in. Results of audits will be presented to QAPI for oversight and any additional recommendations.	

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The survey team conducted the following to verify implementation of the removal plan for F880-K:

1. The survey team reviewed the revised Glucometer-Disinfection Policy.

2. The survey team reviewed the Glucometer Cleaning and Disinfection training materials provided by the SDC on glucometer cleaning and disinfection.

3. The survey team reviewed the training logs for all the staff completed on 10/14/21 and 10/15/21.

4. The survey team verified that each resident requiring accuchecks had resident specific single-use glucometers

5. The survey team interviewed and observed staff working on 10/14/21 and 10/15/21 performing glucometer cleaning for knowledge and proper techniques for glucometer cleaning and disinfection.

6. The survey team verified that an education sign off sheet was in each narcotics book and was completed at shift change during the medication cart handoff for any nurse not previously educated prior to nurse completing any glucometer procedure.

Following validation of the removal plan, the immediate jeopardy was removed on 10/15/21 at 8:20 PM. The deficient practice remained at a lower scope and severity of "E" (pattern of potential for more than minimal harm) following the removal of the immediate jeopardy.

Findings include:

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Review of the facility policy titled "Glucometer Disinfection," dated 10/31/20 and revised on 03/11/21, directs "The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use ... the glucometers should be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus."

Review of the "User Instruction Manual for the Assure Prism Multi Blood Glucose Monitoring System," revised 02/2020, revealed the device manufacturer, ". . . Validated Clorox Healthcare Bleach Germicidal Wipes ...and Super Sani-cloth Germicidal Disposable Wipe [sic] for disinfecting the Assure Prism multi meter."

Observations on 10/12/21 and 10/13/21 revealed that three of four Licensed Practical Nurses (LPN) (LPN 1, LPN2, and LPN4) on Unit 2 failed to appropriately clean and disinfect two of two multi-use glucometers by not cleaning the glucometers after use and/or by not allowing the treated surfaces of the glucometers to remain wet for the full required contact time (four minutes) with the EPA-registered disinfectant, specifically Clorox Disinfecting Wipes, that was currently used by the facility.

During an observation on 10/12/21 at 4:21 PM, LPN1 performed an accucheck on Resident (R) 48 with an Assure Prism glucometer. When LPN1 was finished, she wiped the glucometer with alcohol prep pad(s) and let the glucometer air dry on a tissue on the medication cart. During the observation, LPN1 stated that she generally

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allows the glucometer to air dry after she cleans it with the alcohol wipes. At 4:28 PM, LPN1 then performed an accucheck on R21 using the same Assure Prism glucometer. At 4:30 PM, LPN1 obtained the Solimo Disinfecting Wipes (an EPA registered disinfectant) and PDI Sani-Hands and at 4:36 PM LPN1 wiped the used glucometer with a PDI Sani-Hands for 15 seconds; after 15 seconds the glucometer was not visibly wet. During an interview on 10/12/21 at 4:41 PM, LPN1 stated she usually cleans the glucometer with antimicrobial wipes, wets it down for 10-30 seconds, and allows the glucometer to air dry. When asked how long the glucometer needed to remain wet for the product to be effective as a disinfectant, the LPN1 stated she "wasn't sure, maybe a minute." LPN1 acknowledged that she used the PDI Sani-Hands for cleaning the glucometer and thought it was a disinfectant wipe. LPN1 stated that no one in the facility had instructed her on how to disinfect the multiuse glucometers between resident use.

Review of the product label for PDI Sani-Hands on LPN's medication cart on 10/12/21 at 4:41 PM directs "Antiseptic- for handwashing to decrease bacteria on the skin ... Active ingredient alcohol 70%." This product is not an EPA registered disinfectant.

During an observation on 10/13/21 at 12:12 PM, LPN 2 used the Assure Prism glucometer to check a blood glucose on R67. LPN2 wiped the glucometer for 10 seconds with a Clorox Disinfecting Wipe prior to use and entered the room to perform the accucheck within one minute. When LPN2 finished the accucheck, he wiped the glucometer with a Clorox wipe for five seconds and placed it on a tissue on the

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medication cart. Within a minute, LPN2 used a tissue and waved over the glucometer to "dry it." Continued observation revealed within two minutes, LPN2 gathered the same glucometer used on R67 and performed R20's accucheck. At 12:21 PM, LPN2 wiped the glucometer with a Clorox wipe for five seconds and left it on a tissue on the medication cart to let the glucometer air dry. At 12:23 PM, LPN2 performed R44's accucheck using the same glucometer used on R20. At 12:31 PM, LPN2 wiped the glucometer for six seconds with a Clorox Disinfecting Wipe. At 12:33 PM, LPN performed R48's accucheck using the same glucometer used on R44.

During an interview on 10/13/21 at 12:36 PM, LPN2 stated that he cleans the glucometer with a bleach wipe and stated he "scrubs" the glucometer for 25 seconds and waits for the glucometer to dry; he did not know how long the glucometer was to remain wet. LPN2 acknowledged that he did not ensure that the glucometer remained wet for four minutes prior to use on each resident. LPN2 stated that no one in the facility had instructed him on how to disinfect the multiuse glucometers between resident use.

Review of the product label for the Clorox Disinfecting Wipes on LPN2's medication cart on 10/13/21 at 12:36 PM revealed the wipes "Kills 99.999% of bacteria, kills cold and flu viruses, kills Staph [bacteria], E coli [bacteria], MRSA [bacteria resistant to antibiotic methicillin], Strep [bacteria]. To use to disinfect hard nonporous surfaces. Wipe surface to be disinfected. Use enough wipes for treated surface to remain visibly wet for 4 minutes. Let surface dry." Further review of the product label for the Clorox Disinfecting Wipes revealed the wipes were effective against

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Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV).

Observation on 10/13/21 at 4:00 PM revealed LPN4 gathered an Assure Prism glucometer and put it directly in a small basket on top of opened packets of gauze. Continued observation revealed LPN4 entered R47's room and completed R47's blood glucose check. At 4:05 PM, LPN4 placed the glucometer back into the small basket on top of open gauzes. LPN4 entered the dining room and wiped the glucometer with a "Medline Alcohol Prep Pad 70% Isopropyl Alcohol." Within one-minute LPN4, using the same glucometer used on R47, attempted to perform R27's blood glucose check; however, the surveyor intervened and stopped LPN4.

Interview on 10/13/21 at 4:07 PM with LPN4 revealed she normally cleans the multi-use glucometer with the same alcohol prep pads used during the observation. LPN4 stated no one had trained her to use anything different to disinfect the multiuse glucometer.

Interview on 10/13/21 at 4:10 PM with the Director of Nursing (DON) revealed it was her expectation LPN4 would have cleaned the glucometer with a bleach wipe and then let it dry for five to 10 minutes. The DON stated LPN4 should have never used an alcohol prep pad to clean the glucometer. The DON also stated a bleach wipe should always be used on glucometers to allow for effective disinfection from blood borne diseases

During an interview on 10/13/21 at 4:03 PM, the Infection Preventionist (IP) indicated that the

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expectation was that glucometers were cleaned with Clorox Bleach Wipes after each use and in between residents according to the manufacturer's product instructions.

During an interview on 10/14/21 at 9:30 AM, the Medical Director indicated that his expectation would be that licensed staff follow protocol and "sterilize" glucometers in between each use, or if residents have their own glucometer that they would also be sterilized after each use.

2. Review of CDC guidance, dated 09/10/21, revealed "Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic ... Ensure everyone is aware of recommended IPC practices in the facility ... Establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: . . . who meets criteria for quarantine or exclusion from work . . . "

Review of the "Health Attestation Form" provided by Infection Preventionist (IP), dated 06/10/20, indicated: "Policy: All team members, employed or contracted, pledge to self-monitor and self-report to avoid exposures to communicable disease such as COVID-19 ... As part of our protection activities, we ask for these practices to be attested to by your signature. In addition, we will be asking you to submit to having your temperature taken when you report to work ..."

On 10/12 /21 at 3:50 PM, Certified Nursing Assistant (CNA)1 indicated that she did not screen in upon entry "today" as she "was late and did not arrive to the facility until 7:10 AM." CNA1

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stated that no one told her to screen for COVID and this was her first time at this facility. CNA1 further indicated that she was fully vaccinated for COVID-19.

During an interview on 10/12/21 at approximately 4:10 PM, the IP confirmed that the facility does not have any current staff or residents with COVID-19. The IP further indicated that it is CNA1's first time in the facility and normally when she (the IP) gets into work (around 8:00 AM) she reviews screening with agency staff, but she had not done so with CNA1.

During an interview on 10/12/21 at 4:22 PM, the Director of Nursing (DON) indicated that "100%" of all staff are required to screen at the door, and it doesn't matter what department they are in or if they are agency, the rules apply to all. The DON indicated that she reviewed the nursing screening logs daily and each department head looks at their own staff as well. On holiday's and weekends the charge nurses are to review the screening logs. The DON did verify that the facility had no system to ensure the logs are reviewed.

During this interview, the Administrator asked CNA1 what entrance she used to come into the building. CNA1 stated that the front door was locked, and she pushed the doorbell but didn't hear anything, so she walked around and came in through the laundry room.

During an interview on 10/12/21 at 4:40 PM, the Administrator indicated that staff are all educated regarding the requirement to screen at the entrances and at no point in time are staff to enter the building through a door other than a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495086	A. BUILDING _____ B. WING _____	10/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY POINTE REHABILITATION AND NURSING	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

(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 880	Continued From page 49 designated entrance.	F 880		