STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495115	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 11/16/21 through 11/17/21. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Six Complaints were investigated during the survey (VA00053576= Substantiated with Deficiency, VA00053248= Substantiated with Deficiency, VA00053132= Substantiated with Deficiency, VA00052394= Unsubstantiated, VA00052051= Substantiated with Deficiency, VA00051191= Substantiated with Deficiency) The census in this 196 certified bed facility was 174 at the time of the survey. The survey sample consisted of 13 resident reviews (Residents #1 through #13).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		12/28/21

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

Electronically Signed | 12/07/2021

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review and staff interviews, the facility staff failed to ensure one Resident (Resident # 3) in a survey sample of 13 residents was treated with dignity. Findings included: Review of the clinical record was conducted. Resident # 12 was admitted to the facility with diagnoses of but not limited to Aphasia and Stroke. Resident # 12's most recent MDS (Minimum Data Set) Assessment was a Quarterly Assessment with an ARD (Assessment Review Date) of	F 550	Colonial Heights Rehabilitation and Nursing Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence to comply with the requirements of participation and effort to provide high quality resident care. 1. F550: Resident Rights/Exercise of Rights 1. Resident #3 no longer resides in the facility. Resident #12 continues to reside in the facility and is treated with dignity	

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F 550	Continued From page 2 9/26/2021. Brief Interview for Mental Status Score was 1 indicating Severe Cognitive Impairment. On 11/17/2021 at 9:33 AM, while observing another resident in the sample (Resident # 3), Surveyor F observed Certified Nursing Assistant (CNA) D interacting with Resident # 12 who was self-propelling in her wheelchair while in her bedroom. Resident # 12 was talking and moving aimlessly in her wheelchair. CNA D was heard interacting with Resident # 12. CNA D was talking in a loud, abrupt, and unprofessional tone of voice. The Administrator and Director of Nursing were informed of the findings. No further information was provided.	F 550	and respect. 2. All residents have the potential to be affected by this alleged deficient practice. No other inappropriate communications were observed by the Unit Managers on 11/16/21 and 11/17/21. 3. All staff will be educated by the Facility Educator or a Department Manager on resident rights and how to appropriately communicate with residents. 4. The DON or a Department Manager will randomly observe staff interactions with residents 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure staff are appropriately communicating with residents. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		12/28/21

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F 580	Continued From page 3 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation and in the course of an investigation, the facility staff failed to immediately notify physician and resident representative of a	F 580	1. Residents #1 and #3 no longer reside in the facility. 2. All residents with a change in condition have the potential to be affected	

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F 580	Continued From page 4 change in condition for 2 Resident (#1 and #3) in a survey sample of 13 Residents. The findings included: For Resident #1 the facility staff failed to immediately notify Resident #1's resident representative and physician after a fall on 10/26/21. On 11/16/21 during clinical record review it was found that a "Rehab Services Screening" was done on 10/28/21 at 9:41 AM. This screening was done by PT and under the question "Reason for Screening" the box was checked for "FALL." The text box read as follows: "Spoke with pt, she stated fall occurred when she lost her balance trying to open blinds in room. Pt stated that since fall she has been having 8/10 hip pain and unable to ambulate. Reported to nsg, nurse stated she would contact MD. PT orders requested at this time due to increase in pain and decrease in functional mobility." A review of the nursing progress notes revealed there was no mention of a fall during the month of October 2021. A request was made for a list of incidents and accidents during the month of October and Resident #1's name was listed as having had a fall on 10/26/21. [Please note this fall is 2 days prior to the PT Screening.] On 11/16/21 at 3:42 PM an interview was conducted with the ADON who stated if a fall occurs the facility protocol is to first assess the resident for injury, get a set of vital signs, check range of motion, and mental status, notify the MD and RP, if it was unwitnessed start neuro checks. She stated "So for the paperwork, a skin	F 580	by this alleged deficient practice. An audit on current residents with falls or significant change in condition will be conducted to verify notification of physician and the resident representative. 3. All nurses will be educated by the facility educator or nursing Management (includes DON, ADON, unit managers or supervisor) on notifying a resident's physician or physician on call and the resident's representative when there has been an accident or injury involving the resident, or a significant change in condition. 4. The DON or a nursing management will audit resident incidents and significant change in condition 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure that physician or physician on call and the resident's representative have been notified of any accidents or injuries, or significant changes in condition. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	

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F 580	Continued From page 5	F 580		

assessment, a pain assessment, and a risk management form is done." She also so stated that the care plan should be updated to include the fall and any new interventions put in place. When asked if a progress note should be put into the chart she stated that a note should be in the chart stating when the resident fell, results of assessment, who was notified and any new orders from the physician.

On 11/17/21 a request for the fall investigation was made and the facility gave surveyor C a copy of the "Risk Management Form," when asked if this was part of the "Clinical Record" the DON stated that it was not. The Risk Management form was dated 10/26/21 at 8:32 AM and the risk management form read:

"Incident description - Nurse description - Nurse found resident sitting upright on the floor. ROM [range of motion] WNL [within normal limits]. Resident states she has no pain. No bruising or bleeding present. PERRLA. Resident answers all questions appropriately."

"Resident description - I fell on my rear end.
Immediate action taken - Description called RP. Notified doctor.
Resident take him to the hospital -NO

On 11/17/21 during clinical record review it was noted that the nurse practitioner visited the Resident on 10/26/21 and 10/27/21 and there was no mention of a fall in the notes, however there was a mention of it on 10/28/21 excerpts from the Physician notes are as follows:

10/28/21 at 8:38 PM
"Pt seen lying in bed no distress. No concerns

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F 580	Continued From page 6	F 580		

noted by nursing. C/O right leg/hip pain that started with an unwitnessed/unreported fall last week." [At that time the NP ordered X-rays.]

On 11/17/21 at 3:00 PM a phone call was placed to the NP who stated "I was not informed of the fall until 10/28/21. To be fair neither the Resident nor the staff mentioned it until 10/28/21 at that time I ordered X-Rays."

On 11/17/21 at approximately 2:45 PM an interview was conducted with RN E who stated that she was not aware of Resident #1's fall "until the Resident's daughter called to say that her mother had told her of fall a few days ago and that she was having pain in her hip and leg. I did speak with the NP and got her an order for Tylenol."

On 11/17/21 at 3:00 PM an interview was conducted with the ADON who was asked about the conflicting documentation and she stated that she was not aware that LPN C had not notified the physician or the resident representative because the documentation for Risk Management stated that the nurse had notified both parties.

A review of the facility policy entitled "Change in a Residents Condition or Status" was conducted and excerpts are as follows:
"Page 1
1. The nurse will notify the residents attending physician or physician on call when there has been a (and):
A. Accident or injury involving the resident.
2. Significant change of condition is a major decline or improvement in the resident status that;

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F 580	Continued From page 7 C. Requires interdisciplinary review and or revision to the care plan and; D. Ultimately is based on the judgment of the clinical staff and the guidelines outlined in the resident assessment instrument. 5. Except in medical emergencies, notifications will be made within 24 hours of a change occurring in the residence medical/mental condition or status." On 11/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 580		
F 584 SS=D	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 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;	F 584		12/28/21

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F 584	Continued From page 8 §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 observations, staff interviews and in the course of a complaint investigation, the facility staff failed to maintain a clean and homelike environment for 2 Residents (Resident # 13 and #8) in a survey sample of 13 Residents. 1. For Resident #13 the facility staff failed to maintain a bedside table in a homelike manner. 2. For Resident #8 the facility staff failed to maintain her wheel chair in a clean and homelike manner. The findings included: 1. For Resident #13 the facility staff failed to maintain a bedside table in a homelike manner. On 11/16/21 and 11/17/21, general observations were conducted throughout the entire facility on	F 584	1. Resident #13 had their bedside table repaired. Resident #8 has had their wheelchair cleaned. 2. All residents have the potential to be affected by this alleged deficient practice. An audit conducted by the Maintenance Director on current resident's wheelchairs to clean by the maintenance staff. 3. All staff will be educated by the Facility Educator or Department Manager on the process for wheelchair cleaning, work orders and expectations of wheelchairs and furniture should be maintained in clean and working manner. 4. DON or nursing management will audit resident's wheelchairs and resident furniture 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure that they are clean and in proper working order. Any	

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F 584	Continued From page 9 all 3 nursing units. Details of the observations included the following: Resident #13's room contained a bed side table in disrepair, the top drawer facing was missing. On 11/16/21 at 12:43 PM, an interview was conducted with CNA D. CNA D stated that the bedside table has been like that and happened about 3 days ago. CNA D said a maintenance work order had been submitted for the bedside table. On 11/16/21 at 12:27 PM, an interview was conducted with Employee D, the maintenance director. Employee D provided Surveyor D with a list of pending maintenance work orders that have yet to be completed. The bedside table noted in room 304 was not listed. On 11/16/21 at 1:22 PM, Employee D brought a revised maintenance work order list that did have the bedside table and the work order was entered at 12:48 PM. 2. For Resident #8 the facility staff failed to maintain her wheel chair in a clean and homelike manner. On 11/16/21 at 9 AM, Resident #8 was observed in her room. Her w/c (wheelchair) was noted to have a significant amount of dried food on the seat as well as the front wheel. CNA B entered Resident #8's room to deliver her meal tray and was asked to observe the w/c. CNA B said, "That's nasty and I believe that's where the gnats are coming from". CNA B was unaware of frequency wheelchairs are cleaned. On 11/16/21 at approximately 9:45 AM, LPN D	F 584	identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021.	

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F 584	Continued From page 10 was interviewed. LPN D reported that wheelchairs are cleaned every Wednesday. LPN D accompanied Surveyor D to Resident #8's room and confirmed that the w/c was severely soiled with dried food and further acknowledged it did not appear to have been cleaned in several weeks. On 11/16/21 at 10:10 AM, RN C, the unit manager observed Resident #8's w/c and said, "It's pretty dirty". On 11/17/21, the facility Administrator and DON (Director of Nursing) were made aware of the observations and lack of a clean and homelike environment. No further information was provided. Complaint related deficiency.	F 584		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		12/28/21

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F 610	Continued From page 11 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review, the facility staff failed to thoroughly investigate and failed to report the results of an investigation of an injury of unknown origin to the State Survey Agency, within 5 working days of the incident, for one Resident (Resident # 3) in a survey sample of 13 residents. Findings included: 1. For Resident # 3, the facility staff failed to interview other staff who worked with the resident prior to the discovery of the injury of unknown origin and failed to report the results of the investigation of an injury of unknown origin within 5 working days. The Facility Reported Incident (FRI) was reviewed. The FRI was submitted to the State Agency on 9/3/2021. The FRI described the incident of the CNA noticed Resident # 3's left leg looked shorter than right. She also noted that the resident appeared to show signs of pain with movement. She reported her observations and the resident was then examined by the nursing staff, some minor bruising was noted in the area of her upper left thigh. There have not been any reported falls or trauma, but an x-ray has been ordered to further assess resident." Review of the Facility internal investigation revealed the following documentation Facility internal investigation was completed on	F 610	1. Resident #3 no longer resides in the facility. 2. All residents with an alleged violation have the potential to be affected by this alleged deficient practice. An audit will be conducted by the Administrator on any FRIs from November 1st, 2021, to verify statements from staff were obtained and verify the FRI was reported within the 5 working day period. 3. The DON will be educated by the NHA on thoroughly investigating any alleged violations and reporting timely and obtaining staff statements. 4. NHA or designee will audit any Facility Reported Incidents 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure that they have been reported in timely manner and a thorough investigation completed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	

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COLONIAL HEIGHTS REHABILITATION AND NURSING CENTER	831 ELLERSLIE AVE CHESTERFIELD, VA 23834

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F 610	Continued From page 12	F 610		

-blank
Is attached -No
Will be conducted/Report forward to (name of State Agency) 9/10/21
Signed by the Administrator.
Fax receipt 09/03/21 15:34 (3:34 p.m.)

On 11/17/2021 at approximately 10:05 AM, an interview was conducted with the Director of Nursing who stated she was newly employed at the facility only two days prior to survey and had no personal knowledge about Resident # 3 but would review the clinical record and files of the former Director of Nursing to find any documentation about the injury of unknown origin.

The Director of Nursing stated she would try to locate any documentation regarding the injury of unknown origin sustained by Resident # 3. The Director of Nursing returned to the conference room stating she only found two Witness Statements in the files in the Director of Nursing office. The former Director of Nursing was no longer employed at the facility.

Review of the Witness Statements revealed the following documentation
The first form:
The document was not completely filled out-
The name of the witness was blank
The name of the interviewer was blank.
Under the section; "the following is a statement of the facts as reported by the above named witness was written: "CNA called writer to Room 122 A observe left leg out of alignment."
The form was signed and dated 9-3-2021. The signature was not clear.

The second Witness statement

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F 610	Continued From page 13 Date of interview: 9/3/21 Name of Witness: Blank Name of interviewer: Blank Date of incident: 9/3/2021 Time: 1530 (3:30 p.m.) Resident Name: ____(name of Resident # 3) Under the section; "the following is a statement of the facts as reported by the above named witness was written: " I ____(name of the Licensed Practical Nurse) for 7-3 and 3-11. _____(Resident # 3) tolerated meds (medications), and responsive to voice stimuli. ____(Resident # 3) gets medication twice a shift on 7-3. (Resident # 3 was last seen by nurse at 1400 (2:00 p.m.) for afternoon meds. Resident was observed underneath blankets in bed. No injury was reported for 7-3 shift. However approximately 1530 (3:30 p.m.) on 9/3/21, 3-11 CNA informed nurse to assess resident because her left leg did not look right. The form was signed by the witness and dated 9/3/21. There was no documentation of the evidence of the interviews of other staff who had provided care of Resident # 3 prior to the discovery of the injury of unknown origin as stated in the final report. There were only two witness statements presented to the survey team by the Director of Nursing. The final report was due on 9/10/2021. Review of the Follow up Investigation report revealed the letter was dated 9/13/2021. The FAX receipt documented the date and time as 9/13/2021 at 16:12 (4:12 p.m.) The follow up	F 610		

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F 610	Continued From page 14 report documented the facility interviewed all staff who provided any care for Resident # 3 for the three days leading up to the identification and nobody expressed noting any falls or traumatic events that would have likely caused the fracture. She has been bedbound and non-ambulatory for an extended length of time. The report further stated "The facility feels this was a non-traumatic pathological fracture as a result of decreasing bone density in relation to the aging process and lack of stimulus from a lack of weight bearing activity." The last paragraph had a statement regarding the conclusion of "abuse cannot be substantiated." The final report was submitted on 9/13/2021, ten calendar days and 6 working days after identification of the fracture femur on 9/3/2021. No further information was provided.	F 610		
F 641 SS=D	COMPLAINT DEFICIENCY 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 interview, clinical record review, and facility documentation and during the course of an investigation the facility staff failed to maintain accurate clinical assessment for 1 Resident (#1) in a survey sample of 13 Residents. The findings included:	F 641	1. Resident #1 no longer resides in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. An audit will be conducted on residents with BIMS of 0 to verify accuracy by the MDS staff. 3. All MDS nurses will be educated by	12/28/21

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F 641	Continued From page 15 For Resident #1 the facility staff did not maintain accurate assessments. On 11/16/21 during clinical record review it was found that the Resident's Admission MDS (Minimum Data Set) with an ARD date 9/3/21 coded Resident #1 as follows: "Section C - Cognitive Patterns - C0100 -Should brief interview for mental status be conducted (attempt to conduct an interview with all residents.) 0 -No resident is rarely/never understood. [According to the MDS instructions a score of 99 is unable to assess; a score of 0 is severe cognitive impairment.] A review of the progress notes revealed the following excerpts from the Resident Evaluation completed on admission: "8/30/21 - 11:12 PM-BIMS Score: 0.0 BIMS-Severe Impairment." "8/30/21 - 11:22 PM Type: Resident Evaluation-Oriented to: Person. Evaluation reveals patient wears dentures. Able to hear adequately without a hearing aid or other hearing appliance. Clear speech pattern." On 11/16/21 during clinical record review it was found that a "Rehab Services Screening" was done on 10/28/21 at 9:41 AM. This screening was done by the Rehab dept and under the question "Reason for Screening" the box was checked for "FALL." The text box read as follows: "Spoke with pt. she stated fall occurred when she lost her balance trying to open blinds in room. Pt	F 641	the DON on ensuring that they utilize accurate information as well as identify any inconsistencies in documentation when entering BIMs information in Section C -cognition. 4. DON or designee will randomly audit MDS assessments 5 times a week for 1 week, 3 times a week for 2 weeks and 1 time a week for 4 weeks to ensure that completed assessments are accurate in section C-cognition -BIMS. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	

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F 641	Continued From page 16 stated that since fall she has been having 8/10 hip pain and unable to ambulate. Reported to nag, nurse stated she would contact MD. PT orders requested at this time due to increase in pain and decrease in functional mobility." On 11/17/21 at approximately 3:00 PM an interview was conducted with the ADON who stated that the progress notes do appear to have inaccuracies and inconsistencies. On 11/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		12/28/21

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F 656	Continued From page 17 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 interview, clinical record review, and facility documentation the facility staff failed to develop and implement a comprehensive care plan that included fall risk for 1 Resident (#1) in a survey sample of 13 Residents. The findings include: For Resident #1, facility staff failed to develop and implement a comprehensive care plan that included fall risk even though she has a history of falls and was deemed a high falls risk by the facility. On 11/16/21, during the course of a complaint investigation, a review of the care plan revealed that falls were not addressed in the comprehensive care plan and Resident #1 had a	F 656	1. Resident #1 no longer resides in the facility. 2. All residents identified as a fall risk or after a fall have the potential to be affected by this alleged deficient practice. The DON or a nursing management will conduct an audit on current residents with a fall risk 10 or higher and residents who had a fall since survey 11/16/2021 to verify a fall care plan has been initiated or updated with interventions. 3. All nurses will be educated by the facility educator or a nursing management on the process for residents with a fall risk 10 or higher or had a fall will have a fall care plan initiated or updated 4. DON or nursing management will audit residents who have been identified	

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F 656	Continued From page 18 history of falls prior to entering the facility. The care plan was also not updated post fall on 10/26/21 to include the fall and address interventions to prevent future falls. A review of the record revealed the progress note state Resident #1 is a high fall risk excerpt as follows: "8/20/21 at 10:22 PM - "BIMS Score: 0.0 BIMS-Severe Impairment,Braden Scale Score: 17.0 Braden Score- Low Risk. Fall Risk Score: 10.0 Fall Risk- High" On 11/16/21 at 3:42 PM an interview was conducted with the ADON who stated that care plans should address falls if the Resident is at risk for falls. She also stated that the care plan should be updated to include the fall and any new interventions put in place. When asked to review Resident #1's careplan the ADON did and then stated that falls should have been addressed. On 11/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 656	as a new fall risk or after a fall 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure care plans include fall interventions. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, facility documentation review and	F 677	1. Residents #2 no longer resides in the facility. Resident #7 has received a	12/28/21

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F 677	Continued From page 19 in the course of a complaint investigation, the facility staff failed to provide assistance with ADL's (activities of daily living) for 4 Residents (Resident #2, #7, #8, and #10) and in a survey sample of 13 Residents. The findings included: 1. For Resident #7, the facility staff failed to provide showers. On 11/16/21 at 2:58 PM, an interview was conducted with Resident #7. Resident #7 verbalized that she used to get showers twice a week when [CNA C's name redacted] has time but now CNA C just gives her bed baths. Resident #7 stated she has only gotten 1 shower this month. When asked if she would like showers more often, Resident #7 said, "Of course! At least twice a week, I like my body to be clean". On 11/16/21, a clinical record review was conducted of Resident #7 and revealed the following: * Resident #7 was coded on her ADL (activity of daily living) sheet as being totally dependent upon staff for bathing. * Review of the bathing history for the last 30 days (10/17/21-11/16/21) revealed no evidence of a shower being given and coded that the Resident refused on 7 occasions. Resident #7 was scheduled to receive showers on Tuesday and Fridays. *Further review of the clinical record to include progress notes and care plan did not provide any evidence of Resident #7 refusing showers. Surveyor D was advised that when CNA's give	F 677	shower. Resident #8 has received grooming care and a shower. Resident #10 has received nail care. 2. All dependent residents have the potential to be affected by this alleged deficient practice. The DON and nursing management will conduct an audit to verify shower, nail care and grooming have been received. 3. All nursing staff will be educated by the facility educator or nurse management on providing appropriate bathing and grooming care for dependent residents. 4. DON or nursing management will audit shower/bathing records and observe residents for appropriate grooming 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure showers have been provided and grooming care completed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	

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showers they fill out a form at the nursing station. Review of the 3 ring binder containing forms from 9/8/21-11/16/21, Resident #7 received 2 showers in September, one in October and one in November.

2. For Resident #2, the facility staff failed to provide showers.

Resident #2 was discharged and not able to be interviewed. Review of Resident #2's ADL records from 4/1/21-5/24/21, revealed that Resident #2 received a total of 4 showers. Resident #2 was scheduled to receive showers on Monday and Wednesdays. Frequently the shower tasks was coded as "97- Not Applicable". Further review of the clinical record to include progress notes and care plan did not provide any evidence of Resident #2 refusing baths/showers.

On 11/17/21 at 8:49 AM, an interview was conducted with CNA B. CNA B stated showers are to be given twice weekly but when asked if this is actually taking place, CNA B said, "Sometimes we do" and said CNA C is the person that gives showers on that unit.

On 11/17/21 at 10:06 AM, an interview was conducted with CNA C. When asked about the frequency of showers CNA C said, "Once a month and twice if they get lucky". CNA C said, "We don't have time, with our work load so heavy we are assigned anywhere from 12-20 Residents a day".

On 11/17/21 (Wednesday) at 10:10 AM, Surveyor D observed the shower room to be dry and did

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not appear to be used that day. Surveyor D interviewed, RN C, the unit manager who stated showers were given twice weekly. RN C accompanied Surveyor D to the shower room and confirmed that the shower room had not been in use. RN C further confirmed there were no other locations that showers would be given.

3. For Resident #8, the facility staff failed to provide assistance with personal hygiene to include dressing, grooming and showers.

On 11/16/21 at 3 PM, Surveyor D observed Resident #8 to be sitting in her room, in her wheel chair at the bedside. Resident #8 was wearing a leopard print night gown and had a significant amount of facial hair.

On 11/17/21 at 8:49 AM, Surveyor D observed Resident #8 being assisted to the edge of the bed to eat breakfast. Resident #8 had on the same night gown observed the day prior and still had a significant amount of facial hair. CNA B was present in the room. CNA B was asked about the facial hair and confirmed "by the looks of it" Resident #8 had not been shaved in several weeks. CNA B stated showers are to be given twice weekly but when asked if this is actually taking place, CNA B said, "Sometimes we do" and said CNA C is the person that gives showers on that unit.

On 11/17/21 at approximately 9:55 AM, LPN D accompanied Surveyor D to the room of Resident #8. LPN D stated Residents are showered twice weekly and are shaved during showers. LPN D observed Resident #8 and confirmed she had not

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been shaved in a while. When asked why it is important to shave female Residents with facial hair, LPN D said, "for their dignity". LPN D said that showers are documented in a book at the nursing station.

Review of the 3 ring binder containing the forms LPN D showed her to indicate when baths are given revealed sheets from the time period of 9/8/21-11/16/21. There were no forms for Resident #8 in the book.

On 11/17/21 at 10:06 AM, an interview was conducted with CNA C. When asked about the frequency of showers CNA C said, "Once a month and twice if they get lucky". CNA C said, "We don't have time, with our work load so heavy we are assigned anywhere from 12-20 Residents a day".

On 11/17/21 at 10:05 AM, RN C accompanied Surveyor D to observe Resident #8. RN C was made aware that the leopard print night gown Resident #8 was wearing is the same gown she had on yesterday at 3 PM. RN C confirmed this is not appropriate and Resident #8 should have received assistance with personal hygiene and dressing.

On 11/17/21 (Wednesday) at 10:10 AM, Surveyor D observed the shower room to be dry and did not appear to be used that day. Surveyor D interviewed, RN C, the unit manager who stated showers were given twice weekly. RN C accompanied Surveyor D to the shower room and confirmed that the shower room had not been in use. RN C further confirmed there were no other locations that showers would be given.

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Review of the ADL records for Resident #8 from 10/17/21-11/16/21, revealed Resident #8 had received 2 showers in the month of October and none in November. Further review of the clinical record to include progress notes and care plan did not provide any evidence of Resident #8 refusing personal care to include dressing, shaving and bathing.

4. For Resident #10, the facility staff failed to provide assistance with personal hygiene for nail care.

On 11/17/21, Resident #10 was observed in the hallway and his fingernails were noted on both hands to be extremely long.

On 11/17/21 at approximately 9:55 AM, LPN D was asked to look at Resident #10's nails. LPN D confirmed that Resident #10's nails were extremely long and had not been cut in quite some time.

On 11/17/21 at 10:06 AM, an interview was conducted with CNA C. When asked when Resident's fingernails are cut, CNA C said, "with showers". When asked about the frequency of showers CNA C said, "Once a month and twice if they get lucky". CNA C said, "We don't have time, with our work load so heavy we are assigned anywhere from 12-20 Residents a day".

Review of the facility policy titled, "Activities of Daily Living (ADLs), Supporting" read, "...2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident

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F 677	Continued From page 24 and in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care)..." Review of the facility policy titled, "Bath, Shower/Tub" read, "...Documentation: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who assisted the resident with the shower/tub bath...5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken..." On 11/17/21 at approximately 2:10 PM, the facility Administrator and Director of Nursing were made aware of the findings. No further information was received prior to survey exit. Complaint related deficiency.	F 677		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		12/28/21

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	495115	A. BUILDING _____ B. WING _____	C 11/17/2021

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F 755	Continued From page 25 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to ensure that Resident #6's medication was available for administration on 1/19/21 and 1/20/21. Resident #6 did not receive his physician-ordered Efavirenz-Emtricitab-Tenofoir Tablet for Human Immunodeficiency Virus [HIV] for 1 of 13 sampled residents. The findings include: Resident #6 was admitted to the facility on 1/14/21. Resident #6's diagnoses included HIV, Respiratory Failure, and Lung Cancer. Resident #6's Admission Minimum Data Set, with an assessment reference date of 1/20/21, was reviewed. Resident #6's Brief Interview of Mental Status score was 14, meaning no cognitive	F 755	1. Resident #6 no longer resides in the facility. 2. All residents receiving high-cost medications have the potential to be affected by this alleged deficient practice. An audit will be conducted by the DON to verify any high-cost medication is available to be administered to the resident. 3. All nurses will be educated by the facility educator or nursing management on the process of ordering medications timely. DON will be educated by the NHA on the process of reviewing high-cost medications and/or coordinating with physician on medication regiment. Pharmacy will be educated by the DON to communicate to facility NHA and DON regarding any needed approvals of high-cost medications.	

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F 755	Continued From page 26 impairment. On 11/16/21, a review was conducted of Resident #12's Medication Administration Record for January, 2021. Resident #6 did not receive his physician-ordered Efavirenz-Emtricitab-Tenofoir Tablet as ordered at bedtime on 1/19/21, 1/20/21. According to a nurse's note dated 1/19/21, the medication was not available. The facility was unable to provide documentation of the date that the medication was ordered from the pharmacy. According to an "Unable to Fill Communication", dated 1/19/21, the former Administrator's signature was required due to the following: "High Dollar $3,094.29. Medication cost exceeds facility's High Dollar threshold. An authorized representative muse complete the Authorization Box below and return to pharmacy." The Administrator signed the authorization on 1/26/21. The former Administrator, the Vice President of Clinical Services during the survey, submitted a statement. An excerpt read: "We have made numerous calls to the 2 nurses that administered the medication...we cannot confirm the exact nurse who called for the refill of the medication. The former Director of Nursing was also called with no recall to the medication." When asked about the facility policy regarding medication availability, Employee H stated that the facility is responsible for ensuring that all ordered medications are available for administration in a timely manner.	F 755	4. DON or designee will audit pharmacy alerts for approval for high-cost medications and verify available to be administered. The Physician, resident, and resident representative will be notified if availability is delayed, 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic	F 776		12/28/21

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F 776	Continued From page 27 services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review, and staff interview, the facility staff failed to plan and obtain a physician ordered CT scan of the lumbar spine for one Resident (Resident #5) in a sample of 13 residents. The findings included; Resident #5 was admitted with diagnoses including but not limited to; Fusion of spine lumbar region, and Spinal stenosis lumbar region with neurogenic claudication. On 3-22-21 the Resident had an Orthopedic follow up appointment after her recent spinal fusion surgery with her surgeon at 12:30 p.m. On this appointment the physician ordered a follow up appointment for 5-3-21, a whole body bone scan, and a CT (computed Tomography) scan of the lumbar spine without contrast. The Resident had the follow up appointment with	F 776	1. Resident #5 no longer resides in the facility. 2. All residents requiring CT scans have the potential to be affected by this alleged deficient practice. The DON will conduct an audit on current resident with CT scan orders are scheduled and completed. 3. All nurses and unit clerks will be educated by the DON on reviewing paperwork/orders from physician appointments and ensuring that any CT scans are scheduled and completed. 4. DON or nursing management will audit residents' paperwork from follow up appointments 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure follow up appointments/CT scans are scheduled and completed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months.	

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F 776	Continued From page 28 the orthopedic physician on 5-3-21, and the physician documented that the CT scan had not been completed as ordered on 3-22-21 in that note, and reordered it at this second visit. On 5-7-21 the Resident went to the hospital for the CT procedure and then returned to the facility. On 11-17-21 at 2:00 p.m. nursing unit staff stated the CT scan was overlooked on 3-22-21, and was obtained on 5-7-21, after the 5-3-21 appointment with the Orthopedic Surgeon. Staff were made aware of the failure to obtain the CT scan for Resident #5 in a timely fashion. No further information was provided by the facility.	F 776	5. Date of compliance will be 12/28/2021	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		12/28/21

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F 842	Continued From page 29	F 842		

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening

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F 842	Continued From page 30 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and in the course of a complaint investigation, the facility failed maintain a complete and accurate clinical record for 1 Resident (#1) in a survey sample of 13 Residents. The findings included: 1a) For Resident #1 the facility records were inaccurate in that the Resident was said to have a BIMS of 0 and be aphasic and not able to be understood. Yet the progress notes do not reflect this; 1b) In addition, the Physician wrote an extensive note in the Resident's chart that was meant for another Resident and the error was not discovered until 4 days later. 1a) On 11/16/21 during clinical record review it was found that the Resident's Admission MDS (Minimum Data Set) with an ARD date 9/3/21 coded Resident #1 as having a BIMS (Brief Interview of Mental Status) of 0 indicating severe cognitive impairment. Also the box is checked that the Resident is not understood or rarely understood. However the following are excerpts from Resident	F 842	1. Resident #1 no longer resides in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. An audit of the 72-hour report conducted by the DON and nursing management on current residents to ensure no other residents' information is documented in another resident medical record. 3. All physicians will be educated by the DON on ensuring that they document in the correct clinical record when completing documentation. 4. DON or nurse management will audit residents' documentation 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure all notes do not include another resident documented information in the clinical record. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	

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F 842	Continued From page 31 #1's progress notes: "8/30/21 - 11:12 PM-BIMS Score: 0.0 BIMS-Severe Impairment." "8/30/2021 11:22 PM Type: Resident Evaluation-Oriented to: Person. Evaluation reveals patient wears dentures. Able to hear adequately without a hearing aid. Clear speech pattern." "9/6/2021 6:07 pm Type: Skilled Nursing Note -Resident continues to be alert and verbal. Resident x 1 person assist with ADL care." 1b) On 8/31/21 at 8:58 AM an extensive note was written by the physician. The physician wrote notes for another Resident in Resident #1's chart. The error was not discovered and struck out of Resident #1's record until 9/4/21 at 5:17 PM. On 11/17/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 842		
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	F 880		12/28/21

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F 880	Continued From page 32 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 33 §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 interviews and facility documentation review the facility staff failed to properly dispose of a used urinary catheter bag properly to prevent the spread of infection for 1 Resident (Resident #11) in a survey sample of 13 Residents. The findings included: On 11/17/21 at 8:37 AM, Surveyor D observed the shared bathroom for 2 Resident rooms. On the railing there was what appeared to be a soiled/used urinary catheter bag draped over the railing with urine in it. On 11/17/21 at 8:39 AM, LPN B, the MDS (minimum data set nurse) was observed coming out of one of the adjoining rooms. Surveyor D asked LPN B to observe the bathroom and LPN B stated, "that's a Foley bag". LPN B further confirmed that none of the 4 Residents who share the bathroom currently have a urinary catheter. LPN B confirmed this was not the proper storage for such an item and stated the	F 880	1. Resident #11 the catheter bag was removed from bathroom. 2. All residents with catheters have the potential to be affected by this alleged deficient practice. An audit on current residents was conducted by the DON or nurse management to verify proper disposal of discontinued foley catheters. 3. All nursing staff will be educated on proper maintenance and disposal of used catheter bags by the facility educator or nursing management. 4. DON or nurse management will audit residents' rooms who have catheters discontinued 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure catheter bags are maintained/disposed of properly. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	

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F 880	Continued From page 34 risks of having it hanging over the railing was "bacteria". LPN B then proceeded to dispose of the urinary catheter. On 11/17/21, Surveyor D conducted clinical record reviews for the Residents who shared the bathroom observed earlier. Surveyor D identified that Resident #11 was the only one who had orders for a previous use of a urinary catheter. Resident #11's EHR (electronic health record) revealed a physician order dated 7/16/21, that read, "Urinary catheter: size: 16F balloon size: 10ML change PRN [as needed] for obstruction". This order was discontinued on 10/11/21. On 11/17/21 at 10:51 AM, an interview was conducted with RN B, the facility Infection Preventionist. RN B was notified of the observation of the urinary catheter drain bag being stored on the bathroom railing. RN B confirmed this was an infection control concern because, "It [the catheter bag] harbors bacteria that can grow and it should be thrown away". On 11/17/21, a review of the facility policy titled, "Infection Control" read, "Policy Statement: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections". On 11/17/21, the Director of Nursing was made aware of the observations aforementioned. No further information was provided.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		12/28/21

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F 921	Continued From page 35 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and in the course of a complaint investigation, the facility staff failed to maintain a sanitary and comfortable environment for Residents on 1 nursing unit in a sample of 3 nursing units inspected. The findings included: On 11/16/21 and 11/17/21, general observations of the facility cleanliness and comfortable conditions was conducted. The following observations were noted: The 100 unit identified as the Tyler unit was noted to not be maintained in a clean and sanitary manner. Observations included the following: * Room 101 behind the room door had significant wall damage and exposed threads of a previous repair and the baseboard was pulling away from the wall. * Floor tiles in the bathroom of room 102 was discolored and stained. The exterior room wall was in disrepair with unrepaired damage to the sheet rock and holes noted. The exterior wall of the room around the p-tac (heating and cooling unit) had significant cracks and broken sheet rock. * Room 103 bathroom had a gap of exposed subflooring around the commode. * Room 107 had floor tiles that were loose and coming up.	F 921	1. Room 101 has had wall repaired, room 102 has had floor tiles cleaned and drywall repaired, room 103-bathroom floor repaired, room 107 floor tile have been repaired, room 116 wall cracks have been repaired, room 126 has been cleaned, room 131 baseboard molding and sheetrock have been repaired, and room 132-bathroom floor tiles have been cleaned. 2. All residents have the potential to be affected by this alleged deficient practice. An audit of the Residents room will be conducted by the Director of Environmental Services of resident rooms to identify areas that require repair. 3. Environmental service department will be educated by the NHA on ensuring resident rooms are cleaned properly and maintained in good repair. 4. Director of Environmental Services or designee will audit 5 resident rooms 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for 4 weeks to ensure rooms are clean and in good repair. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 36	F 921		

* Room 116 had significant cracks on the exterior room wall.
* Room 126 had a copious amount of buildup of dirt and grime around the exterior walls and corners.
* Room 131 had the baseboard molding coming off of the wall and the sheet rock had significant damage.
* Room 132 had significant staining and discoloration to the tiles in the bathroom.

Throughout this Tyler unit, the rooms had a build-up of dirt and grime around all edges and corners of the rooms that was a copious amount.

On 11/16/21 at 12:27 PM, an interview was conducted with Employee D, the housekeeping/maintenance director. Employee D provided Surveyor D with a list of pending maintenance work orders that have yet to be completed. Review of this log revealed only 1 of the above noted issues as being in process for repair and that was room 131 which had been entered on 11/12/21.

On 11/16/21 at 3:50 PM, the facility Administrator was taken to observe some of the above noted areas. The facility Administrator confirmed the observations of the unclean rooms and rooms in poor disrepair, he stated that many of the items identified by the surveyor had already been identified by him. He further stated that the Tyler unit was undergoing some renovations when the COVID-19 pandemic began and the work had to be halted and had not resumed as of yet.

On 11/17/21 at 9:58 AM, an interview was conducted with Other Employee B, a housekeeper. Other Employee B stated that daily

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	495115	A. BUILDING _____ B. WING _____	C 11/17/2021

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F 921	Continued From page 37	F 921		

she sweeps and mops Resident rooms, takes the trash out and cleans the bathroom. Other Employee B stated that she is the only housekeeper for her assigned unit often and this is all she really has time to do. She did say the department manager/Employee D schedules for rooms to be deep cleaned (where all items are removed and the room is cleaned thoroughly) but they don't have time to do it.

On 11/17/21 at 10:06 AM, an interview was conducted with CNA C. CNA C was asked about the cleanliness of the facility and she said, "I know we aren't supposed to wear gloves in the halls but I have a problem touching anything in this place without gloves, it doesn't look clean enough for me".

On 11/17/21 at 10:19 AM, an interview was conducted with Other Employee C, another housekeeper. Other Employee C said she cleans the bathrooms, sweeps and mops and removes the trash in rooms daily. Other Employee C stated they are down several people in the department and she is the only housekeeper for her wing and doesn't have time to do a thorough job of cleaning.

On 11/17/21 at 12:17 PM, an interview was conducted with Employee D the housekeeping/maintenance manager. Employee D confirmed that they are short several staff members in the department. When asked about the deep cleaning of rooms he indicated he has a schedule for each room to be deep cleaned once per month. A copy of the schedule was provided. When asked if he has a system to track when it is actually done and completed he indicated no. Employee D had no evidence/records of when

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F 921	Continued From page 38 rooms are actually deep cleaned. Employee D confirmed that being able to deep clean rooms once per month has been a challenge to accomplish. On 11/17/21 at approximately 2:10 PM, the facility Administrator and Director of Nursing were notified again of the findings. No further information was provided. Complaint related deficiency.	F 921		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and facility documentation review and in the course of a complaint investigation, the facility staff failed to maintain an effective pest control program ensure the facility is free of pests on 1 Resident care unit in a survey sample of 3 Resident care units. The findings included: On 11/16/21 at 11:45 AM, initial tour was conducted on all 3 nursing units within the facility. During this observation, Surveyor D observed in one Resident room on the 100 unit, several dead bugs, which appeared to be cockroaches, throughout the room. Surveyor D also observed in this same room, a live cockroach; as the Surveyor stepped out of the room into the hall another live cockroach was observed.	F 925	1. 100 unit has been treated by pest control company. 2. All residents have the potential to be affected by this alleged deficient practice. 3. All facility staff will be educated by the facility educator on the process of pest siting and to communicate any pest issues to Director of Environmental Services to be addressed by pest control services. Environmental services department will be educated by the Director of Environmental Services on ensuring resident rooms are cleaned properly and maintained in good repair. 4. Director of Environmental Services or designee will randomly audit resident rooms 5 times a week for 1 week, 3 times a week for 2 weeks, and 1 time a week for	12/28/21

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F 925	Continued From page 39 Surveyor D asked RN D, the unit manager to accompany her to the Resident room. RN D, confirmed the observations and acknowledged that the facility had pest control come on 11/12/21, and performed treatment on the entire hall for roaches. On 11/16/21 at 12:41 PM, Surveyor D met with Employee D, the maintenance director. The maintenance director confirmed that the pest control company was called due to reports of roaches and they did treat areas within the facility on Friday. On 11/16/21 at 1:23 PM, Employee D provided the survey team with pest control records for the year 2021. Review of these documents revealed multiple sighting and treatments performed for roaches. Details are as follows: 1. On 1/19/21, "...Pest activity found during service: Kitchen Area-Interior-The following pest(s) were noted during service cockroaches noted underneath dish machine". 2. On 3/2/21, "...The following pest(s) were noted during service Cockroaches noted in the activity room kitchen..." 3. On 4/9/21, "...Service related comments: treated rooms [room numbers redacted] for cockroaches..." 4. on 5/27/21, "...treated all rooms in the first hallways in the Tyler wing..." 5. on 6/3/21, "...treated all rooms on second hallways of Tyler Hall wing..." 6. On 7/9/21, "...treated room [room number redacted] for possible cockroaches. No live cockroaches noted..." 7. On 9/14/21, "...Treated rooms [4 room	F 925	4 weeks to ensure rooms are free of any pests. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision for 3 months. 5. Date of compliance will be 12/28/2021	

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F 925	Continued From page 40 numbers redacted] for cockroaches... Patient/Guest rooms- Interior- The following pest(s) were noted during service cockroaches noted in rooms [room number of 4 rooms redacted]..." 8. On 11/11/21, " ...Patient/Guest rooms- Interior- The following pest(s) were noted during service cockroaches noted in room [room number of 1 room redacted]..." On 11/16/21 at 2:29 PM, a meeting was held with the facility Administrator. He was notified of the pest sightings in a Resident room. When asked about pest control interventions, he said, "Yes they [pest Control Company] come out regularly and we call them when we have issues. We've been calling them out separately to address different issues". When asked if he feel it is working and effective, the Administrator said "I have been reevaluating our vendor yes". The Administrator confirmed he has concerns with pest control effectiveness. Review of the facility policy titled, "Pest Control" read, "This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents". On 11/17/21 at approximately 2:00 PM, the facility Administrator was made aware of the findings. No further information was provided. Complaint related deficiency.	F 925		