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CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Medicaid/Medicare abbreviated survey was conducted on 03/23/21 through 03/26/21. No corrections are required for Emergency Preparedness compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 114 bed facility was 102 at the time of the survey. The survey sample consisted of 35 residents.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/23/21 through 03/26/21 Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 114 certified bed facility was 102 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 5 closed record reviews	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	F 550		5/7/21

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

Electronically Signed | 04/12/2021

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F 550	Continued From page 1 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, 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, staff interview, and facility documentation, the facility staff failed to provide dignity and respect for 1 Resident (Resident #47) of 35 residents in the survey sample. The facility staff failed to provide Resident #47	F 550	1. The facility staff failed to provide dignity and respect for one resident during wound care, by writing on the residents wound dressing after applying it to the residents' right upper buttock. Resident #47 not affected. ADON in-serviced on providing dignity during wound care on	

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F 550	Continued From page 2 dignity and respect during wound care as evidenced by writing on the resident's wound dressing after applying it to the resident's right upper buttock. The findings included: Resident #47 was admitted to the nursing facility on 01/22/21. Diagnosis included but not limited to Pressure Ulcer of Right Upper Buttock, Stage 3 and Muscle Weaknesses. The current Minimum Data Set (MDS) an Admission Assessment MDS with an Assessment Reference Date (ARD) of 01/28/21 coded the resident with a 5 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS). This indicated Resident #47's cognitive abilities for daily decision making were severely impaired. In addition, the Minimum Data Set coded Resident #47 as requiring extensive assistance of two persons for bed mobility, extensive assistance of one person for dressing and personal hygiene. Requires total dependence for eating with the assistance of one person and total dependence of one person for toileting. Section M. Skin Conditions, M0300 of the MDS indicates that resident was admitted with a Stage 3 pressure ulcer. On 3/24/21 at 1:30 PM, the surveyor observed the ADON (Assistant Director of Nursing/ Administrative Staff) #3 provide wound care to the wound on Resident #47's upper right buttock. Post treatment the ADON applied a sacral dressing over the resident's wound and then took a black marker and proceeded to write the date, time and initial on the dressing. On 3/24/21 at approximately 2:00 PM the ADON	F 550	3/26/2021. 2. Resident currently residing in the facility that currently have wounds have the potential to be affected. A quality monitor review will be conducted by the DON/Designee to ensure that dignity and respect is maintained during wound care procedures. 3. Licensed nursing staff will be educated by the DON/Designee on the policy for residents' rights on the resident having the right to have dignity and respect during wound care. . Random wound observations will be conducted by the DON/Designee weekly x 6 weeks, to ensure that respect and dignity is maintained, during wound care. 4. The results of the quality monitoring, will be reported to the quality assurance committee team monthly for review and analysis. 5. Date of Completion – May 7, 2021	

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F 550	Continued From page 3 was asked, when performing wound care, when do you usually write the date, time and initial. She stated, "I usually do it before I put it on her." On 3/24/21 at approximately, 3:00 PM a debriefing was conducted with the Facility Administrator, The Regional Director of Clinical Services and with the DON (Director of Nursing) concerning the above issue. No comments were voiced.	F 550		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not	F 567		5/7/21

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F 567	Continued From page 4 exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on a facility reported incident, resident personal funds review, resident interviews, staff interviews and facility document review the facility staff failed to ensure that 2 of 35 residents in the survey sample were allowed to manage their own financial affairs/facility personal funds account in regards to a Covid Stimulus Check, Resident #14 and Resident #100. The findings included: 1. Resident #14 was admitted to the facility on 9/12/18 with diagnoses to include but not limited to Hypertension, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. The most recent MDS (Minimum Data Set) for Resident #14 was a Quarterly Assessment with a ARD (Assessment Reference Date) of 12/18/20. Resident #14's BIMS (Brief Interview for Mental Status) score was a 14 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making.	F 567	1. Resident #14 and Resident #100 notified that audits of their stimulus funds were conducted. Both residents informed of the findings, that an error had occurred and that funds had been returned to their individual RFMS accounts. 2. Audit of stimulus funds for all residents completed utilizing report pulled from report developed by Resident Fund Management System. The Executive Director, Regional Director Business Office Manager, and Corporate Trust Fund Coordinator review the report. Follow up based on findings of audit. 3. Business Office team members will be educated regarding protection and tracking of Stimulus funds provided on a recurring basis. Corporate training conducted for all Business Office team members: re: RFMS Stimulus Tracking Report.	

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F 567	Continued From page 5 A Facility Reported Incident (FRI) received at the Office of Licensure and Certification(OLC on 8/13/20 was reviewed and is documented in part, as follows: Report Date: 8/13/2020 Resident involved: Name (Resident #14) Incident type: Resident property misappropriated. Describe incident, including locations and action taken: Stimulus payments received in resident's trust accounts. Business Office Manager withdrew the funds and applies to past due patient liabilities. Name of employee involved and their positions: Name (Previous BOM) Business Office Manager. Employee action initiated or taken: Business Office Manager suspended pending further investigation. Facility internal investigation: Will be conducted/Reported forward to VDH(Virginia Department Health)/OLC: 8/19/2020. Name and Title of Reporting Person: Name, Executive Director (Previous Executive Director). The facility's 5 day FRI Investigation dated 8/19/20 was reviewed and is documented in part, as follows: RE (regarding): Initial Report 8/13/2020 Incident: Allegation of misappropriation of resident funds. Investigation: On August 14, 2020 an audit was conducted and it was determined that residents at the Center had funds withdrawn from their stimulus payments and applied to past due liabilities without the resident's authorization. Findings: Upon completion of the investigation misappropriation of resident funds did occur.	F 567	4. Stimulus funds will be monitored monthly utilizing reports pulled from reports developed by the Resident Fund Management System. The results of the Quality Monitoring will be reviewed at monthly QAPI meeting for review, analysis, and further recommendations. 5. Date of completion – May 7, 2021	

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Actions and On-Going Interventions:
1. On 8/12/2020 Name (Previous BOM) was suspended pending completion of investigation.
2. On 8/19/2020 Name (Previous BOM) was terminated,
3. Name (Resident#14) was refunded $831.00. This is the amount taken from his stimulus check without authorization.

On 3/23/21 at approximately 2:00 P.M. a phone interview was conducted with Resident #14 regarding his Covid Stimulus Check and asked if he had signed any facility documents for the money to be used for any past due balances. Resident #14 stated, "No, I haven't signed anything. I didn't even know I got any money."

On 3/25/21 at 9:13 A.M. a phone interview was conducted with the previous Executive Director. The previous Executive Director was asked about Resident #14's misappropriation of funds he reported to OLC on 8/13/2020. The previous Executive Director stated, "I was contacted by Name (Ombudsman) because Resident #14's family contacted him in regards to the account.. So I looked into it. Name (previous BOM) was the Business Office Manager at the time and we did suspend her pending investigation. There was an audit done and the stimulus check was used without permission. Corporate had said we couldn't use the Covid stimulus for past due balances. Name (previous BOM) had received training from regional and told not to use the stimulus money unless it had been authorized by the resident or the power of attorney. We also did a lot of conference calls with corporate and were told no stimulus money was to be used for past due balances. When I approached Name

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(previous BOM) she had no answer why she did it, she said she did do it but didn't know why. Name (previous BOM) said she remembered being told and trained about what to do and not to do with the stimulus money. Corporate said I had to terminate her. We terminated her and paid back the resident's money. The Regional Director of Business Office Services did a 100% audit of all resident's who got stimulus checks and one other resident was found Name (Resident #100) to have money taken as well. What happened constitutes misappropriation of funds."

On 3/25/21 at 9:58 A.M. a phone interview was conducted with the Ombudsman regarding Resident #14's stimulus check. The Ombudsman stated, "I received a call from the resident's family (Resident #14) alleging that the facility took money from the resident's stimulus check without permission. I called the facility and spoke with the Name (previous Executive Director) who agreed to get with his business office manager to check on the stimulus check. On 8/14/20 Name (previous Executive Director) called and told me an audit was done at the facility by the Administrator and the BOM and it was determined that the BOM had in fact taken money from the stimulus check without getting permission from the resident or the resident's power of attorney. There was a past due amount on the resident's bill and the money from the stimulus check was used to pay that past due amount. Name (previous Executive Director) agreed to replace the funds that were taken from the resident."

On 3/25/21 at 10:07 A.M. a phone interview was conducted with the Traveling Business Office

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Manager regarding Resident #14's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the account on 4/30/20 in the amount of $1200.00. On 6/1/20 $831.00 was pulled out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 $831.00 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident did have a past due balance of $1408.00."

On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #14's stimulus money and personal fund account. The Vice President of Revenue Cycle stated, "I would have expected Name (previous BOM) to have met with the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permission. When I asked Name (previous BOM) why she removed the funds without written permission she said she had spoken to the family about using the stimulus funds and sent an authorization in a returned stamped envelop, but the authorization was never returned by the family. The funds should have never been pulled before the written authorization was received. A second resident (Resident#100) was also found on the audit where stimulus funds had been removed without authorization."

A signed statement dated 3/25/21 by the Regional Director of Business Office Services was reviewed and is documented in part, as follows:

I received an email regarding a complaint filed by the family of Name (Resident #14) regarding his

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Stimulus funds. I conducted an audit of Name (Resident #14's) account and discovered that they were used for cost of care. I contacted Name (previous BOM) and requested the backup to support the use of funds. Name (previous BOM) said the daughter has given verbal consent, and she had mailed her the forms to sign and send back. Name (previous BOM) said she had contacted the daughter numerous times asking why she had not sent back the forms, but she wouldn't answer or return her calls. I told her that she should not have moved the funds until she had the written authorization and she knew this was the process. Name (previous BOM) said, "I'm sorry, I know I should have waited.". I concluded my audit of Name (Resident#14's) account and based on my findings, instructed that the funds be returned to his account and resident family notified of the outcome. I then conducted a 100% audit of all residents that received stimulus funds."

The facility policy titled "Stimulus Payment Tracking Report" dated 9/2020 was reviewed and is documented in part, as follows:

Coronavirus stimulus monies are not to be used to pay an outstanding AR (accounts receivable) balance without written permission from the resident or responsible party. This written permission must be kept in the resident's financial file.

The facility policy titled "Virginia Resident's Rights and Responsibilities" effective 1/2007 was reviewed and is documented in part, as follows:

Accommodation of Needs:
J. To manage your financial affairs and to not be

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required to deposit your funds with the nursing facility.

On 3/25/21 at 3:00 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Regional Director of Clinical Services the above information was shared. Prior to exit no further information was provided.

2. Resident #100 was admitted to the facility on 11/26/2019 with diagnoses to include but not limited to Diabetes Mellitus, Hypertension and Major Depressive Disorder.

The most recent MDS (Minimum Data Set) for Resident #100 was a Quarterly Assessment with a ARD (Assessment Reference Date) of 3/8/21. Resident #100's BIMS (Brief Interview for Mental Status) score was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making.

The facility's 5 day FRI Investigation dated 8/19/20 was reviewed and is documented in part, as follows:

RE (regarding): Initial Report 8/13/2020
Incident: Allegation of misappropriation of resident funds.
Investigation: On August 14, 2020 an audit was conducted and it was determined that residents at the Center had funds withdrawn fro their stimulus payments and applied to past due liabilities without the resident's authorization.

Findings: Upon completion of the investigation misappropriation of resident funds did occur.

Actions and On-Going Interventions:

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1. On 8/12/2020 Name (Previous BOM) was suspended pending completion of investigation.
2. On 8/19/2020 Name (Previous BOM) was terminated,
3. Name (Resident#100) was refunded $644.34. This is the amount taken from her stimulus check without authorization.

On 3/24/21 at approximately 10:15 A.M. a phone interview was conducted with Resident #100 regarding her Covid Stimulus Check and asked if she had signed any facility documents for the money to be used for any past due balances. Resident #100 stated, "I haven't signed any papers. Can you tell me how much money I received because this is the first I have heard about it."

On 3/25/21 at 9:13 A.M. a phone interview was conducted with the previous Executive Director. The previous Executive Director was asked about Resident #100's misappropriation of funds he reported to OLC on 8/19/2020. The previous Executive Director stated, "there was an audit done and the stimulus check was used without permission. Corporate had said we couldn't use the Covid stimulus for past due balances. The Regional Director of Business Office Services did a 100% audit of all resident's who got stimulus checks and one other resident was found Name (Resident #100) to have money taken as well. What happened constitutes misappropriation of funds."

On 3/25/21 at 10:07 A.M. a phone interview was conducted with the Traveling Business Office Manager regarding Resident #100's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the

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account on 4/29/20 in the amount of $1200.00. On 7/22/20 $644.34 was pulled out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 $644.34 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident did have a past due balance of $2624.79."

On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #100's stimulus money and personal fund account. The Vice President of Revenue Cycle stated, "I would have expected Name (previous BOM) to have met with the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permission. The funds should have never been pulled before written authorization was received.

The facility policy titled "Stimulus Payment Tracking Report" dated 9/2020 was reviewed and is documented in part, as follows:

Coronavirus stimulus monies are not to be used to pay an outstanding AR (accounts receivable) balance without written permission from the resident or responsible party. This written permission must be kept in the resident's financial file.

The facility policy titled "Virginia Resident's Rights and Responsibilities" effective 1/2007 was reviewed and is documented in part, as follows:

Accommodation of Needs:
J. To manage your financial affairs and to not be

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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 567	Continued From page 13 required to deposit your funds with the nursing facility. On 3/25/21 at 3:00 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Regional Director of Clinical Services the above information was shared. Prior to exit no further information was provided.	F 567		
F 574 SS=D	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and	F 574		5/7/21

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F 574	Continued From page 14 (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by:	F 574		

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F 574	Continued From page 15 Based on responses from six residents during a group interview and general observations, the facility staff failed to ensure the residents were aware of the contact information for all State regulatory and informational agencies to include email, mailing addresses and telephone numbers in a font large enough to be read by residents. The findings included: On 3/24/21 at 1:30 p.m., a group interview was conducted with 6 residents that represented all units. During the group interview, Resident Council President (RCP)-Resident #100 and the remaining 5 residents expressed that they were not aware of where the State Regulatory and informational agencies contact information posting was located within the facility. It was asked of the group if in-house procedures for filing a grievance failed to resolve a complaint regarding care and services, abuse, neglect, exploitation and or misappropriation of property, what other recourse would they have? They all stated no one had ever given them the information and they did not know where the information was posted. This surveyor was also unable to locate the aforementioned postings. On 3/25/21 at approximately 1:30 p.m., the Activities Director escorted RCP-Resident #100 and this surveyor to the front lobby to located the postings. RCP-Resident #100 found an 8" by 11" white sheet of paper in a plastic frame sitting at the receptionist front desk with the State Agency names, mailing and email addresses. RCP-Resident #100 was not able to read the contents on the paper due to small font. The Administrator joined the group and stated there	F 574	1. During the group interview on 3/24/21, resident #100 and 5 residents expressed that they were not aware of where the State Regulatory and informational agencies contact information posting was located within the facility and that the information was not posted in a font large enough to be read by residents. An updated, larger poster has been posted in the front lobby on bright colored paper with large font. 2. Community Life Director, or Designee, will review information with all residents on where the posted information is located for State Regulatory and informational agencies in the facility. 3. Community Life Director, or Designee, will provide all residents with education on posted information for State Regulatory and informational agencies regarding – location of information in the facility and agencies listed. Follow up education will take place in monthly Resident Council meetings and as needed. 4. Any resident concerns will reviewed immediately and at the monthly QAPI meetings for review, analysis, and further recommendations. 5. Date of Completion – May 7, 2021	

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F 574	Continued From page 16 was another posting down the front hallway from the front lobby. RCP-Resident #100 went to the second posting which was the same size, but posted on the wall. Again, Resident #100 was not able to read its contents based on the small font. RCP-Resident #100 stated to the Administrator and the Activities Director that there was no way residents would be able to know that the framed document was located on the wall or in the front lobby was the document with State Agency information in order to independently file a grievance to resolve a personal complaint regarding care and services or abuse and neglect. The font in the framed document on the wall was also in the same small font as the one in the front lobby. The RCP-Resident #100 asked the Administrator and the Activities Director if she was in trouble because she did not know where the posting was located or its content. The Administrator assured the RCP-Resident #100 that she was not in any trouble and they would present the information at the next resident council meeting, make the information more accessible and increase the font. On 3/25/21 at approximately 2:00 p.m., during the debriefing with the Administrator and Director of Nursing (DON), they stated they followed Federal and State regulation regarding the requirements for posting State Agency contact information.	F 574		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §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	F 602		5/7/21

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F 602	Continued From page 17 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on a facility reported incident, resident personal funds review, resident interviews, staff interviews and facility document review the facility staff failed to prevent the misappropriation of resident federal stimulus check funds for 2 of 35 residents in the survey sample, Resident #14 and Resident #100. The findings included: 1. Resident #14 was admitted to the facility on 9/12/18 with diagnoses to include but not limited to Hypertension, Chronic Obstructive Pulmonary Disease and Congestive Heart Failure. The most recent MDS (Minimum Data Set) for Resident #14 was a Quarterly Assessment with a ARD (Assessment Reference Date) of 12/18/20. Resident #14's BIMS (Brief Interview for Mental Status) score was a 14 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. A Facility Reported Incident (FRI) received at the Office of Licensure and Certification(OLC on 8/13/20 was reviewed and is documented in part, as follows: Report Date: 8/13/2020 Resident involved: Name (Resident #14) Incident type: Resident property misappropriated. Describe incident, including locations and action taken: Stimulus payments received in resident's trust accounts. Business Office Manager	F 602	1. An audit was conducted and it was determined that Resident #14 and Resident #100 had funds withdrawn from their stimulus payments and applied to their past due liabilities without their authorization. Resident funds have been returned to their individual accounts. 2. Audit of stimulus funds for all residents completed utilizing report pulled from report developed by Resident Fund Management System. The Executive Director, Regional Director Business Office Manager, and Corporate Trust Fund Coordinator review the report. Follow up based on findings of audit. 3. Business Office team members will be educated regarding protection and tracking of Stimulus funds provided on a recurring basis. 4. Stimulus funds will be monitored monthly utilizing reports pulled from reports developed by the Resident Fund Management System. The results of the Quality Monitoring will be reviewed at monthly QAPI meeting for review, analysis, and further recommendations. 5. Date of completion – May 7, 2021	

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withdrew the funds and applies to past due patient liabilities.
Name of employee involved and their positions: Name (Previous BOM) Business Office Manager.
Employee action initiated or taken: Business Office Manager suspended pending further investigation.
Facility internal investigation: Will be conducted/Reported forward to VDH(Virginia Department Health)/OLC: 8/19/2020.
Name and Title of Reporting Person: Name, Executive Director (Previous Executive Director).

The facility's 5 day FRI Investigation dated 8/19/20 was reviewed and is documented in part, as follows:

RE (regarding): Initial Report 8/13/2020
Incident: Allegation of misappropriation of resident funds.
Investigation: On August 14, 2020 an audit was conducted and it was determined that residents at the Center had funds withdrawn fro their stimulus payments and applied to past due liabilities without the resident's authorization.

Findings: Upon completion of the investigation misappropriation of resident funds did occur.

Actions and On-Going Interventions:
1. On 8/12/2020 Name (Previous BOM) was suspended pending completion of investigation.
2. On 8/19/2020 Name (Previous BOM) was terminated,
3. Name (Resident#14) was refunded $831.00. This is the amount taken from his stimulus check without authorization.

On 3/23/21 at approximately 2:00 P.M. a phone

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interview was conducted with Resident #14 regarding his Covid Stimulus Check and asked if he had signed any facility documents for the money to be used for any past due balances. Resident #14 stated, "No, I haven't signed anything. I didn't even know I got any money."

On 3/25/21 at 9:13 A.M. a phone interview was conducted with the previous Executive Director. The previous Executive Director was asked about Resident #14's misappropriation of funds he reported to OLC on 8/13/2020. The previous Executive Director stated, "I was contacted by Name (Ombudsman) because Resident #14's family contacted him in regards to the account.. So I looked into it. Name (previous BOM) was the Business Office Manager at the time and we did suspend her pending investigation. There was an audit done and the stimulus check was used without permission. Corporate had said we couldn't use the Covid stimulus for past due balances. Name (previous BOM) had received training from regional and told not to use the stimulus money unless it had been authorized by the resident or the power of attorney. We also did a lot of conference calls with corporate and were told no stimulus money was to be used for past due balances. When I approached Name (previous BOM) she had no answer why she did it, she said she did do it but didn't know why. Name (previous BOM) said she remembered being told and trained about what to do and not to do with the stimulus money. Corporate said I had to terminate her. We terminated her and paid back the resident's money. The Regional Director of Business Office Services did a 100% audit of all resident's who got stimulus checks and one other resident was found Name (Resident #100) to have money taken as well.

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What happened constitutes misappropriation of funds."

On 3/25/21 at 9:58 A.M. a phone interview was conducted with the Ombudsman regarding Resident #14's stimulus check. The Ombudsman stated, "I received a call from the resident's family (Resident #14) alleging that the facility took money from the resident's stimulus check without permission. I called the facility and spoke with the Name (previous Executive Director) who agreed to get with his business office manager to check on the stimulus check. On 8/14/20 Name (previous Executive Director) called and told me an audit was done at the facility by the Administrator and the BOM and it was determined that the BOM had in fact taken money from the stimulus check without getting permission from the resident or the resident's power of attorney. There was a past due amount on the resident's bill and the money from the stimulus check was used to pay that past sue amount. Name (previous Executive Director) agreed to replace the funds that were taken from the resident."

On 3/25/21 at 10:07 A.M. a phone interview was conducted with the Traveling Business Office Manager regarding Resident #14's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the account on 4/30/20 in the amount of $1200.00. On 6/1/20 $831.00 was pulled out of the account by Name (previous BOM) as a care cost payment. On 9/8/20 $831.00 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident did have a past due balance of $1408.00."

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On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #14's stimulus money and personal fund account. The
Vice President of Revenue Cycle stated, "I would have expected Name (previous BOM) to have met with the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permission. When I asked Name (previous BOM) why she removed the funds without written permission she said she had spoken to the family about using the stimulus funds and sent an authorization in a returned stamped envelop, but the authorization was never returned by the family. The funds should have never been pulled before the written authorization was received. A second resident (Resident#100) was also found on the audit where stimulus funds had been removed without authorization."

A signed statement dated 3/25/21 by the Regional Director of Business Office Services was reviewed and is documented in part, as follows:

I received an email regarding a complaint filed by the family of Name (Resident #14) regarding his Stimulus funds. I conducted an audit of Name (Resident #14's) account and discovered that they were used for cost of care. I contacted Name (previous BOM) and requested the backup to support the use of funds. Name (previous BOM) said the daughter has given verbal consent, and she had mailed her the forms to sign and send back. Name (previous BOM) said she had contacted the daughter numerous times asking why she had not sent back the forms, but she wouldn't answer or return her calls. I told her

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that she should not have moved the funds until she had the written authorization and she knew this was the process. Name (previous BOM) said, "I'm sorry, I know I should have waited.". I concluded my audit of Name (Resident#14's) account and based on my findings, instructed that the funds be returned to his account and resident family notified of the outcome. I then conducted a 100% audit of all residents that received stimulus funds."

The facility policy titled "Abuse, Neglect, Exploitation and Misappropriation" last revised 11/28/17 was reviewed and is documented in part, as follows:

Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, permanent use of a resident's belongings or money without the resident's consent. Misappropriation includes but is not limited to:
-Identity theft
-Theft of money from bank accounts
-Unauthorized or coerced purchases on a resident's credit card
-Unauthorized or coerced purchases from resident's funds

The facility policy titled "Stimulus Payment Tracking Report" dated 9/2020 was reviewed and is documented in part, as follows:

Coronavirus stimulus monies are not to be used to pay an outstanding AR (accounts receivable) balance without written permission from the resident or responsible party. This written permission must be kept in the resident's financial file.

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On 3/25/21 at 3:00 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Regional Director of Clinical Services the above information was shared. Prior to exit no further information was provided.

2. Resident #100 was admitted to the facility on 11/26/2019 with diagnoses to include but not limited to Diabetes Mellitus, Hypertension and Major Depressive Disorder.

The most recent MDS (Minimum Data Set) for Resident #100 was a Quarterly Assessment with a ARD (Assessment Reference Date) of 3/8/21. Resident #100's BIMS (Brief Interview for Mental Status) score was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making.

The facility's 5 day FRI Investigation dated 8/19/20 was reviewed and is documented in part, as follows:

RE (regarding): Initial Report 8/13/2020
Incident: Allegation of misappropriation of resident funds.
Investigation: On August 14, 2020 an audit was conducted and it was determined that residents at the Center had funds withdrawn fro their stimulus payments and applied to past due liabilities without the resident's authorization.

Findings: Upon completion of the investigation misappropriation of resident funds did occur.

Actions and On-Going Interventions:
1. On 8/12/2020 Name (Previous BOM) was suspended pending completion of investigation.

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2. On 8/19/2020 Name (Previous BOM) was terminated,
3. Name (Resident#100) was refunded $644.34. This is the amount taken from her stimulus check without authorization.

On 3/24/21 at approximately 10:15 A.M. a phone interview was conducted with Resident #100 regarding her Covid Stimulus Check and asked if she had signed any facility documents for the money to be used for any past due balances. Resident #100 stated, "I haven't signed any papers. Can you tell me how much money I received because this is the first I have heard about it."

On 3/25/21 at 9:13 A.M. a phone interview was conducted with the previous Executive Director. The previous Executive Director was asked about Resident #100's misappropriation of funds he reported to OLC on 8/19/2020. The previous Executive Director stated, "there was an audit done and the stimulus check was used without permission. Corporate had said we couldn't use the Covid stimulus for past due balances. The Regional Director of Business Office Services did a 100% audit of all resident's who got stimulus checks and one other resident was found Name (Resident #100) to have money taken as well. What happened constitutes misappropriation of funds."

On 3/25/21 at 10:07 A.M. a phone interview was conducted with the Traveling Business Office Manager regarding Resident #100's person fund account. The Traveling BOM stated, "The resident's stimulus check was deposited in the account on 4/29/20 in the amount of $1200.00. On 7/22/20 $644.34 was pulled out of the account

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CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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by Name (previous BOM) as a care cost payment. On 9/8/20 $644.34 was refunded to the resident as a reverse care cost credit. On 8/13/20 the resident did have a past due balance of $2624.79."

On 3/25/21 at 10:28 A.M. a phone interview was conducted with the Vice President of Revenue Cycle regarding Resident #100's stimulus money and personal fund account. The Vice President of Revenue Cycle stated, "I would have expected Name (previous BOM) to have met with the resident/POA and to have received signed permission to use the funds in the account from the stimulus for the back balance. The money should not have been touched without receiving written permission. The funds should have never been pulled before written authorization was received.

The facility policy titled "Abuse, Neglect, Exploitation and Misappropriation" last revised 11/28/17 was reviewed and is documented in part, as follows:

Misappropriation of resident property is the deliberate misplacement, exploitation, or wrongful, temporary, permanent use of a resident's belongings or money without the resident's consent. Misappropriation includes but is not limited to:
-Identity theft
-Theft of money from bank accounts
-Unauthorized or coerced purchases on a resident's credit card
-Unauthorized or coerced purchases from resident's funds

The facility policy titled "Stimulus Payment

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F 602	Continued From page 26 Tracking Report" dated 9/2020 was reviewed and is documented in part, as follows: Coronavirus stimulus monies are not to be used to pay an outstanding AR (accounts receivable) balance without written permission from the resident or responsible party. This written permission must be kept in the resident's financial file. On 3/25/21 at 3:00 P.M. during a pre-exit debriefing with the Administrator, the Director of Nursing and the Regional Director of Clinical Services the above information was shared. Prior to exit no further information was provided.	F 602		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility.	F 622		5/7/21

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Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

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

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F 622	Continued From page 28 facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation review the facility staff failed to send a copy of the Resident's Care Plan to include their goals after being transferred and admitted to the hospital for two residents (Resident #91 and #94) in survey sample of 35 residents. The findings included: 1. The facility staff failed to send a copy of Resident #94's Plan of Care summary to include	F 622	1. The facility failed to send a copy of Care Plans for two residents that were discharged/transferred to the hospital: Resident #94 discharged to the hospital on 1/25/21 Resident #91 discharged to the hospital on 8/9/2020 2. Director of Nursing or Designee will conduct a Quality Review of resident documentation that transferred/discharged to the hospital over the last 30 days. Follow up based on	

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F 622	Continued From page 29 plan care goals was sent upon transfer/discharge to the hospital on 01/25/21. Resident #94 was re-admitted to the facility 02/02/21. Diagnosis for Resident #91 included but were not limited to Hypertension, Diabetes - Type 2, Bipolar Disorder and Heart Failure. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 12/02/20 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS). A nursing note dated 1/25/21 indicated: "Resident #94 was discharged from the facility and transferred to the hospital." During an interview on 3/25/21 at 11:13 A.M. with the administrator she stated, " A care plan was not sent to the hospital upon discharge from the facility for Resident #94." 2. The facility staff failed to ensure that Resident #91's Plan of Care Summary to include care plan goals was sent upon transfer/discharge to the hospital on 08/09/20. Resident #91 was originally admitted to the facility on 09/29/17. Diagnosis for Resident #91 included but not limited to Chronic Obstructive Pulmonary Disease (COPD.) The current Minimum Data Set (MDS), a quarterly	F 622	findings. 3. Director of Nursing or Designee to educate licensed nurses on providing required documentation to include care plan goals, bed hold policy, and physician documentation. The Director of Nursing or Designee will review information provided during resident transfers to receiving facility/hospital for 6 weeks and as needed to ensure the required documentation is provided. 4. The results of the Quality Monitoring to be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, and further recommendations. 5. Date of Completion – May 7, 2021	

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assessment with an Assessment Reference Date (ARD) of 03/01/21 coded the resident with a 06 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment.

The Discharge MDS assessments was dated for 08/09/20 - discharged with return anticipated.

On 08/09/20, according to the facility's documentation read in part, "Resident #91, was observed ambulating out of her room towards nurse's station and was met by staff member, noted facial drooping to left side of face, drooling from the mouth and mumbling her words. The on call physician made aware with new orders to send Resident #91 out via 911 to the local hospital. VS: (BP) 120/78, (P) 72, (R) 18, (T) 97.5 with oxygen saturation at 100%.

A phone interview was conducted with the Administrator on 03/26/21 at approximately 2:03 p.m., who stated, "The Care Plan should have been sent with Resident #91 when discharged out to the hospital.

The Administrator and Director of Nursing (DON) was informed of the finding during a briefing on 03/25/21 at approximately 2:55 p.m. The facility did not present any further information about the findings.

The facility's policy titled: Transfer/Discharge Notification and Right to Appeal with a revision date of 03/26/18.
Policy: Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements.

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F 622	Continued From page 31 Documentation include but not limited to: Information provided to the receiving provider must include but is not limited to: Comprehensive care plan goals.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of	F 623		5/7/21

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this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and

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F 623	Continued From page 33 email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document reviews, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman in writing of discharges for two residents (Resident #43 and #94) in the sample of 35 residents. The findings included: 1. The facility staff failed to notify the Office of the State Long - Term Care Ombudsman in writing when Resident #94 was transferred to the hospital on 1/25/21.	F 623	1. The Ombudsman was not notified of Resident #43 (6/11/20) and Resident #94 transfer from the facility to the hospital on 1/25/2021. Ombudsman to be notified of transfer for Resident #94 and Resident 43 as of 4/12/2021. 2. An audit of residents discharged from the facility in the past 30 days will be completed to ensure Ombudsman notification. Follow up based on findings. 3. The Director of Social Services will be educated on the notification process for	

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F 623	Continued From page 34 Resident #94 was re-admitted to the facility 02/02/21. Diagnosis for Resident #91 included but were not limited to Hypertension, Diabetes - Type 2, Bipolar Disorder and Heart Failure. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 12/02/20 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS). A nursing note dated 1/25/21 indicated: "Resident #94 was discharged from the facility and transferred to the hospital." A phone interview was conducted with the Social Worker (SW) on 03/25/21 at approximately 9:02 a.m. The SW stated, "I am not able to locate the transmittal slip to validate the Ombudsman was made aware of Resident #94's discharge to the local hospital on 01/25/21." The Administrator and Director of Nursing (DON) was informed of the finding during a briefing on 03/25/21 at approximately 2:55 p.m. The facility did not present any further information about the findings. 2. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #43's transfer to the local hospital on 06/11/20. Resident #43 was originally admitted to the facility on 07/13/17. Diagnosis for Resident #43 include but not limited to generalized anxiety disorder. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date	F 623	Ombudsman notification by the Executive Director. The Interdisciplinary Team will review transfers and discharges during the clinical meeting to ensure proper notifications are made within 30 days of discharge or transfer. 4. Findings will be reported to the QAPI Committee monthly for review, analysis, and further recommendations. 5. Date of Completion – May 7, 2021	

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(ARD) of 01/21/21 coded the resident with a 03 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no severe cognitive impairment.

The Discharge MDS assessments was dated for 06/11/20 - discharged assessment - return not anticipated.

On 6/11/2020, according to the facility's documentation, "Resident was noticed by this nurse having an unsteady gait and resident was leaning toward her right side. Resident almost fell trying to walk numerous times due to her unsteady gait. The Nurse Practitioner (NP) was notified with a new order to send Resident #43 out via 911 to the hospital for possible stroke.

A phone interview was conducted with the Social Worker (SW) on 03/25/21 at approximately 9:02 a.m. The SW stated, "I am not able to locate the transmittal slip to validate the Ombudsman was made aware of Resident #43's discharge to the local hospital on 06/11/20."

The Administrator and Director of Nursing (DON) was informed of the finding during a briefing on 03/25/21 at approximately 2:55 p.m. The facility did not present any further information about the findings.

The facility's policy titled: Transfer/Discharge Notification and Right to Appeal with a revision date of 03/26/18.
Policy: Transfer and discharges of residents, initiated by the center (facility initiated) will be conducted according to Federal and/or State regulatory requirements.

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F 623	Continued From page 36 Notice must be made as soon as practicable before transfer or discharge. Note: Notices to the ombudsman in these situations can be sent when practicable, such as a list of residents on a monthly basis.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:	F 625		5/7/21

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F 625	Continued From page 37 2. The facility staff failed to ensure that Resident #91 was provided a written copy of the facility's bed-hold and reserve bed payment policy upon transfer/discharge to the hospital on 08/09/20. Resident #91 was originally admitted to the facility on 09/29/17. Diagnosis for Resident #91 included but not limited to Chronic Obstructive Pulmonary Disease (COPD.) The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 03/01/21 coded the resident with a 06 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. The Discharge MDS assessments was dated for 08/09/20 - discharged with return anticipated. On 08/09/20, according to the facility's documentation read in part, "Resident #91, was observed ambulating out of her room towards nurse's station and was met by staff member, noted facial drooping to left side of face, drooling from the mouth and mumbling her words. The on call physician made aware with new orders to send Resident #91 out via 911 to the local hospital. VS: (BP) 120/78, (P) 72, (R) 18, (T) 97.5 with oxygen saturation at 100%. On 03/25/21 at approximately 2:03 p.m., a phone interview was conducted with the Administrator, who stated, "The bed hold policy should have been sent with the resident when discharged to the hospital." The Administrator and Director of Nursing (DON) was informed of the finding during a briefing on 03/25/21 at approximately 2:55 p.m. The facility	F 625	1. Resident #91 was transferred to the hospital on 8/9/2020 Resident #94 was transferred to the hospital on 1/25/2021 and readmitted to the facility on 2/2/2021. Bed hold policy provided to both residents as of 4/9/2021. 2. The Director of Nursing, or Designee, will conduct a Quality Review of residents discharged over the last 30 days to determine if a bed hold policy was sent with the resident upon transfer to the hospital Follow up based on findings. 3. Director of Nursing, or Designee, will educate licensed nurses on required documentation with hospital transfers to include bed hold policy and care plan goals. The DON, or Designee, will review information provided during resident transfers, to include appropriate documentation, for 6 weeks, and as needed. 4. The results of the Quality Monitoring to be reviewed at the monthly QAPI meetings for review, analysis, and further recommendations. 5. Date of Completion – May 7, 2021	

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F 625	Continued From page 38 did not present any further information about the findings. Based on resident record review, staff interviews and facility document review, the facility staff failed to provide two residents (Resident #91 and (#94) with a Bed Hold Policy prior to being transferred to a hospital, in the survey sample of 35 residents.	F 625		

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F 625	Continued From page 39 The findings included: 1. Resident #94 was re-admitted to the facility 2/2/21 with diagnoses which included hypertension, type two diabetes, Bipolar disorder and heart failure. The facility staff failed to provide a copy of the facility's Bed Hold Policy prior to being transferred to the hospital on 1/25/21. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 12/02/20 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS). A nursing note dated 1/25/21 indicated: "Resident #94 was discharged from the facility and transferred to the hospital." During an interview on 3/25/21 at 11:13 A.M. with the administrator she stated, " A Bed Hold Policy was not given to Resident #94 prior to transferring to the hospital." The facility staff failed to provide a copy of the facility's Bed Hold Policy to Resident #94 prior to being transferred to the hospital.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility's	F 641	1. Resident #70 MDS modified on 3/25/21 to accurately reflect the resident's	5/7/21

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F 641	Continued From page 40 staff failed to accurately code the 2/18/21 quarterly MDS assessment at sections "H0100" Bowel and Bladder Appliances and "H0300" Urinary continence for 1 of 35 residents (Resident #70), in the survey sample. The findings included: Resident #70 was originally admitted to the facility 8/29/20 and had never been discharged from the facility. The current diagnoses included; stroke, hemiparesis, an enlargement of the prostate gland, and a neurogenic bladder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/18/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #70's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with toileting. In section "H" the resident was coded for no appliances such as an indwelling catheter, an intermittent catheter, and at the best description of urinary continence the resident was coded as always incontinent. Resident #70 had a physician order dated 10/1/20, for an indwelling Foley catheter secondary to neurogenic bladder. Review of the Treatment Administration Record from 2/12/21 through 2/18/21, revealed Resident #70 did have an indwelling catheter in place and catheter care was provided.	F 641	use of an indwelling catheter. 2. Quality monitor review will be conducted by MDS Coordinator of assessments completed within the past 30 days to ensure accuracy of “H0100” and “H0300”. Follow up will be based on findings. 3. MDS Coordinator will be educated on MDS accuracy according to the RAI manual, to include completion of “H0100” and “H0300” by the Regional MDS Coordinator. Prior to submission of MDS Assessments, the IDT will review the assessment date to verify accuracy of these sections. The Executive Director, or Designee, will complete quality monitor review weekly for 6 weeks to validate MDS assessment accuracy. 4. Findings will be reported to the QAPI Committee monthly for review, analysis, and further recommendations. 5. Date of Completion – May 7, 2021	

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The current care plan had a problem which read; (name of the resident) has Indwelling catheter related to a neurogenic bladder. The goal read; (name of the resident) will be/remain free from catheter-related trauma through review date. (name of the resident) will be free of symptoms of urinary tract infection (UTI) through review date. The interventions included; Catheter care every shift and as needed. Change catheter and bag as ordered. Monitor/document for pain/discomfort due to catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Refrain from allowing drainage bag to rest on floor.

During an interview with Resident #70 on 3/23/21 at approximately 1:50 p.m., a bedside drainage bag was observed attached to the bed frame. The resident was unable to state if he was utilizing an indwelling catheter or a condom catheter. .

The Resident Assessment Instrument (RAI) manual stated at "H0100" to check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days. A. read indwelling catheter (including suprapubic catheter and nephrostomy tube). (RAI manual, MDS 3.0 chapter 3 page H-2).

The (RAI) manual stated at at "H0300" to code 9, not rated: if during the look back period the resident had an indwelling bladder catheter, condom catheter, ostomy or no urine output (e.g. is on chronic dialysis with no urine output) for the entire 7 days. (RAI manual, MDS 3.0 chapter 3 page H-8).

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F 641	Continued From page 42 An interview was conducted with the MDS Coordinator on 3/25/21 at approximately 11:27 a.m. The MDS Coordinator stated the MDS was inaccurate at sections "H0100" and "H0300" and a modification of the MDS assessment would be made. At approximately 12:40 p.m., the MDS Coordinator presented a copy of the modified assessment. The modified assessment stated the resident utilized an indwelling catheter at "H0100" and his urinary continence at "H0300" was not rated. On 3/25/21, at approximately 2:00 p.m. the above information was shared with the Executive Director, the Director of Nursing and the Corporate Consultant. An opportunity was offered to the facility's staff to present additional information but no additional information was provided.	F 641		
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 clinical record review, staff interview and facility documentation, the facility staff failed to provide supervision and implement interventions to reduce environmental hazards for one resident (Resident #4) in the survey sample of 35 residents.	F 689	Past noncompliance: no plan of correction required.	4/12/21

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The findings included:

Based on observations, clinical record review, staff interviews and Past- Non- Compliance Plan of Corrections the facility staff failed to provide supervision and implement interventions to reduce environmental hazards for one resident (Resident #4) in the survey sample of 35 residents.

The findings included:

The facility staff failed to provide supervision and implement interventions to reduce environmental hazards for one resident (Resident #4).

The facility presented evidence of Past-Non-Compliance in response to an elopement of Resident #4.

Resident #4 was admitted to the facility on 11/05/19 with diagnoses that included the following: Alzheimer's Disease, Peripheral Vascular Disease, Exfoliative dermatitis, Pruritus, Psoriasis, Disorder of urea cycle, Xerosis cutis, and Anxiety. Resident BIMS score is 3 completed on 7/28/20.
Resident #4 was able to walk out of the facility with an activated wander guard on 7/23/20 and 7/26/20.

Initial Report 7/26/20

Incident: "Report of resident elopement. Resident assessed by a licensed nurse, no injuries because of this incident. Responsible Party and NP notified."

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F 689	Continued From page 44 Investigation: "Upon investigation of the incident, reported that the resident had been up ambulating in the hallway with her walker. Statement collected from one of the CNA's on the unit stated that she was sitting at the nurses station going over her assignment for charting and she noticed that the resident was outside of the unit door at the end of the hallway 'Just standing there." She heard the door click which prompted her to look up from her charting. She immediately went to the door to open it and escorted the resident back in without further incident. When asked what she was trying to do, the resident stated, "I wanted to be in the sun so I could kill the bugs that are crawling on me. The heat will kill them." Upon further investigation, it was discovered that the following actions contributed to the incident: Resident has Wander Guard device in place, however, the door she exited out of was not a door secured for the Wander guards. Root Cause of the incident was that the alarm for the door was disarmed from the panel at the nurses' station due to staff exiting out of the door to the parking lot. Door generally alarms when pushed open if set appropriately. The alarm panel is not secured, allowing staff to disarm. Findings: Upon completion of the investigation the resident did elope, however, the resident did not leave the property and did not sustain any injuries while she was outside of the facility. Actions and On-Going Interventions: 1. Staff education on Elopement Policy and Procedures initiated. Staff will also be educated on the locked box and disarming the doors.	F 689		

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2. Head to toe assessment completed by a licensed nurse to assess for injuries. Resident's skin also checked to ensure no bugs were present on her skin or in/on her clothing. None present.

3. Care Plan updated, to include interventions for scratching. Care plan and behavior monitoring updated to include exit seeking along with triggers and pharmacological and non-pharmacological interventions.

4. NP assessed the resident. Current interventions in place for the resident include:
a. Aquaphor Ointment three times a day for psoriasis
b. Tea Tree Oil topically daily for Exfoliative dermatitis
c. Permethrin Cream every 7 days - Wash off for 12 hours after applying for suspected scabies exposure
d. Bendaryl 25 mg. every 8 hours as needed for itching
e. Cetaphil cream-apply to skin daily
f. Ketoconazole Shampoo- apply to scalp topically eery 4 days for 4 weeks for psoriasis - to be completed on 8/24
g. Prednisone 10 mg. by mouth daily for psoriasis
h. Gabepentin 100 mg by mouth at bedtime for pruritus for 14 days - To be completed 8/6
i. Buspar 5 mg. v by mouth daily for 14 days for Generalized anxiety- To complete on 8/7

5. All alarms on the panel immediately checked to ensure proper functioning by Nursing Supervisor.

6. Maintenance Director installed locked box to alarm panels at each nursing station with key provided. Keys to the locked boxes will be kept on

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medication carts.

7. Nursing staff will ensure box is secured every shift. If any concerns with securing the box, these will be reported to the Maintenance Director immediately.

8. The facility will continue to conduct ongoing training on Elopement. All additional incidents of elopement will be reported as required. Information will be reported to QAPI committee monthly for further compliance and or revision."

Resident #4 had an Elopement Risk Evaluation dated 7/16/19 that indicated:
1. Resident is cognitively impaired

2. Resident is independently mobile

3. Resident have poor decision-making skills

4. Resident has not demonstrated exit seeking behaviors

5. Resident is not oblivious to safety needs

6. Does the resident have a history of elopement, no

7. Does the resident have the ability to exit the facility, yes

8. Based on potential risk factors above, resident is determined to be at risk for elopement, NO

Resident #4 had an Elopement Risk Evaluation dated 7/26/19 that indicated:

1. Resident is cognitively impaired

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F 689	Continued From page 47 2. Resident is independently mobile 3. Resident have poor decision-making skills 4. Resident has demonstrated exit seeking behaviors 5. Resident is not oblivious to safety needs 6. Does the resident have a history of elopement, yes - If yes how many times (2) 7. Does the resident have the ability to exit the facility, yes 8. Based on potential risk factors above, resident is determined to be at risk for elopement, YES A Care Plan Dated 6/24/20 indicated: "Focus: Resident #4 is an elopement risk due to impaired safety awareness, confusion; Goal- The resident's safety will be maintained through the review date. The resident will not leave facility unattended through the review date. Intervention- Electronic monitoring device, monitor for function and placement daily." Physician Progress Note dated 7/23/20 at (12:29) indicated: "Chief complaint: Agitation, Pruritis and attempted elopement - Resident #4 walked outside exit door, She was brought back in by NP and Resident #4 stated she wanted some sunlight for her pruritis, stating "it will help kill these bugs on me." No visible bugs noted on skin." Nursing Progress Note dated 7/26/20 at (10:45 A.M.) indicated: " Resident seen standing outside	F 689		

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of the building a few feet from the door where she exited. The exit was not witnessed. The alarm on the door did not go off, and resident does have a wander guard on. When resident was seen outside she was promptly brought back inside. When asked why she was outside she stated "the sun will get these bugs or evidence of bug bites on skin."

Nursing Progress Note dated 7/26/20 at (14:02 P.M.) indicated: "Elopement assessment, and skin assessment completed. Behavioral problems are delusions when the resident was asked about he discomfort, Resident claimed, I wanted to get some sun to kill all the bugs that are on me."

During an interview on 3/25/21 at 10:13 A.M. with the Maintenance Director he stated, no one made him aware that the door was not functioning properly. The Maintenance Director stated he check the doors once a week. The Maintenance Director stated, he placed a locked key system on the door to ensure the alarm could not be disarmed.

During an interview with the Administrator on 3/25/21 at 10:30 A.M. she stated, staff had been using the door to go in and out of the building to the staff parking lot.

Observations made during the survey indicated a staff parking lot was in close proximity to the exit door.

A facility Delayed Egress Operation Policy indicated: "Visually inspect door to insure proper signage is in place to read "Push until alarm sounds door can be opened in 15 seconds."

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F 690	Continued From page 49	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		5/7/21

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F 690	Continued From page 50 Based on observation, staff interview, and clinical record review, the facility's staff failed to ensure appropriate care and services were provided to prevent/reduce trauma to the urethra and bladder, and other complications while utilizing an indwelling catheter for 1 of 35 residents (Resident #70), in the survey sample. The findings included: Resident #70 was originally admitted to the facility 8/29/20 and had never been discharged from the facility. The current diagnoses included; stroke, hemiparesis, an enlargement of the prostate gland, and a neurogenic bladder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/18/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #70's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with toileting. In section "H" the resident was coded for no appliances such as an indwelling catheter, an intermittent catheter, and at the best description of urinary continence the resident was coded as always incontinent. Resident #70 had a physician order dated 10/1/20, for an indwelling Foley catheter secondary to neurogenic bladder. The current care plan had a problem which read; (name of the resident) has Indwelling catheter related to a neurogenic bladder. The goal read;	F 690	1. The facility failed to ensure resident #70, had a securement device in place while having an indwelling catheter in place. Securement device placed immediately upon identification of deficient practice. 2. Quality monitor review of residents with physicians' orders for indwelling catheters, will be reviewed by the DON or Designee, to ensure securement devices are in place. Follow up based on findings. 3. Licensed nursing staff, will be educated by DON or Designee on following physicians' orders and providing services in accordance with professional standard of practice for indwelling catheters. The DON or Designee will complete random observations, to ensure securement devices are in place on those residents with indwelling catheters weekly x 6 weeks, will complete random observations. 4. The results of the quality monitoring, will be reported to the quality assurance committee team monthly for review analysis. 5. Date of Compliance: May 7, 2021	

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(name of the resident) will be/remain free from catheter-related trauma through review date. (name of the resident) will be free of symptoms of urinary tract infection (UTI) through review date. The interventions included; Catheter care every shift and as needed. Change catheter and bag as ordered. Monitor/document for pain/discomfort due to catheter. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Refrain from allowing drainage bag to rest on floor.

On 3/23/21 at approximately 1:50 p.m., a bedside drainage bag was observed attached to the bed frame. The resident was unable to state if he was utilizing an indwelling catheter or a condom catheter. Again on 3/24/21 at approximately 10:50 a.m. a bedside drainage bag was observed attached to the bed frame and the catheter tubing was observed with light yellow urine in it. On 3/25/21 at approximately 10:55 a.m., an observation was made of the residents catheter with Licensed Practical Nurse (LPN) #1. The resident had an indwelling catheter to a bedside drainage bag. The indwelling catheter wasn't secured and/or stabilized. LPN #1 stated the catheter should have been secured at the thigh but; apparently when the catheter drainage tubing was changed a few days ago because of a large amount of sediment in the tubing the staff forgot to attach the stabilizer. LPN #1 covered the resident and explained she would be back to secure the catheter to his thigh.

The facility's policy titled Catherization, Male and Female Urinary with a revision date of 9/19/17 read under Male Catherization at bullet #9; Secure catheter to the thigh to prevent tugging.

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F 690	Continued From page 52 Taping the catheter is a frequent method used for stabilization. The drainage tube attached to the catheter is taped to the person's thigh or abdomen. The area of the thigh is the best site for taping with women. Men to secure the catheter use the site of the thigh or lower abdomen. (http://www.public.asu.edu/) On 3/25/21, at approximately 2:00 p.m. the above information was shared with the Executive Director, the Director of Nursing and the Corporate Consultant. The Director of Nursing stated the resident's indwelling catheter should have been secured aid in preventing accidental removal and/or trauma.	F 690		
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;	F 758		5/7/21

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F 758	Continued From page 53 §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended 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 resident record record review, staff interviews and facility document review the facility staff failed to ensure a gradual dose reduction for Trazadone was followed through for 1 of 35 Resident's in the survey sample, Resident #88. The findings included: Resident #88 was admitted to the facility on 7/18/19 with diagnoses to include but not limited to Schizoaffective Disorder, Bipolar Disorder and	F 758	1. The facility failed to ensure a gradual dose reduction for Trazadone was completed for Resident #88. MD notified on 3/25/2021 for resident assessment needed for GDR. 2. Resident currently residing in the facility that, are prescribed psychotropic medication have the potential to be affected. A quality monitor review will be conducted by the DON/Designee to	

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F 758	Continued From page 54 Major Depressive Disorder. The most recent MDS (Minimum Data Set) for Resident #88 was a Quarterly Assessment with a ARD (Assessment Reference Date) of 3/2/21. Resident #88's BIMS (Brief Interview for Mental Status) score was a 15 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Under Section NO410 Medications Received, C. Medication received Days: Antidepressant-7. Resident #88's Pharmacy Consultation Report for 10/1/20 through 10/30/20 was reviewed and is documented in part, as follows: Recommendation date 10/10/20. Comment: Name (Resident #88) Trazadone 50 mg(milligrams) QHS (every day at bedtime). Recommendation: Please attempt a gradual dose reduction (GRD), with the end goal of discontinuation, while concurrently monitoring for reemergence of target and/or withdrawal symptoms. Rationale for Recommendation: A GDR should be attempted in 2 separate quarters, with at least 1 month between attempts, within the first year in which an individual is admitted on a psychotropic medication or after the facility has initiated such medication, and then annually unless clinically contraindicated. Physician's Response: I accept the recommendation above WITH THE FOLLOWING MODIFICATION: Decrease Trazadone to 25mg QHS.	F 758	ensure residents with orders to GDR are completed. 3. Licensed nursing staff will be educated by the DON/Designee on the policy for GDR and following through with the physician's order. Random observations will be conducted by the DON/Designee weekly x 6 weeks, to ensure that GDR's are completed timely and as ordered. 4. The results of the quality monitoring, will be reported to the quality assurance committee team monthly for review and analysis. 5. Date of Compliance: May 7, 2021.	

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F 758	Continued From page 55	F 758		

Physician Signature: Name (Medical Doctor)
Date: 10/29/20.

Resident #88's Medication Administration Records (MARS) dated 10/1/2020-3/25/2020 were reviewed and are documented in part, as follows:

10/1/2020: Trazodone HCL tablet 100 mg Give 0.5 tablet by mouth at bedtime related to BIPOLAR Disorder. -Start Date-09/15/2020

11/1/2020: Trazodone HCL tablet 100 mg Give 0.5 tablet by mouth at bedtime related to BIPOLAR Disorder. -Start Date-09/15/2020

12/1/2020: Trazodone HCL tablet 100 mg Give 0.5 tablet by mouth at bedtime related to BIPOLAR Disorder. -Start Date-09/15/2020

1/1/2021: Trazodone HCL tablet 100 mg Give 0.5 tablet by mouth at bedtime related to BIPOLAR Disorder. -Start Date-09/15/2020

2/1/2021: Trazodone HCL tablet 100 mg Give 0.5 tablet by mouth at bedtime related to BIPOLAR Disorder. -Start Date-09/15/2020

3/1/2021: Trazodone HCL tablet 100 mg Give 0.5 tablet by mouth at bedtime related to BIPOLAR Disorder. -Start Date-09/15/2020

Resident #88's current Physician Orders were reviewed and are documented in part, as follows:

Order Summary: Trazadone HCL Tablet 100 MG Give 0.5 tablet by mouth at bedtime related to BIPOLAR DISORDER.

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Order Status: Active
Order Date: 9/15/2020
Start Date: 9/15/2020

Resident #88's Comprehensive Care Plan was reviewed and is documented in part, as follows:

Focus:
Name (Resident #88) is on antipsychotic therapy related to bi-polar disorder, schizoaffective disorder.
Date Initiated: 11/01/2019.

Interventions:
-Administer Antipsychotic medications as ordered by physician. Monitor behavioral symptoms and side effects. Date Initiated: 11/01/2019.
-Dose reduction attempts per evaluation if clinically indicated. Date Initiated: 11/01/2019.

Resident #88's Progress Notes were reviewed and are documented in part, as follows:

3/25/2021 16:01 P.M. (4:01) Nursing Progress Note:
Note Text: This writer notified NP (Nurse Practitioner), concerning GDR of residents Trazadone from 10/29/20 that was not completed. She stated she would need to assess the resident before agreeing to this GDR due to her not being the provider at the time this GDR was written. The plan is to continue the current treatment.

On 3/25/21 at 1:02 P.M. a phone interview was conducted with the Regional Director of Clinical Services regarding Resident #88's Trazadone GDR order from 10/29/20. The Regional Director of Clinical Services stated, "Last night when we were pulling her GDR documents for you we

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F 758	Continued From page 57 found that the GDR for the Trazadone dated 10/29/20 was not followed through with. The GDR did not happen. We called the new Medical Doctor about it and were told she would have to come in to assess the resident first before changes could be made because she was not the attending when the GDR was ordered on 10/29/20." The facility policy titled "Medication Management-Psychotropic Medications" last revised on 3/23/2018 was reviewed and is documented in part, as follows: POLICY: The center implements gradual dose reduction unless clinically contraindicated and a PRN (as needed) order for psychotropic medication is limited. Procedure: 10. Gradual dose reduction (GDR) to be attempted per accepted standards of practice unless clinically contraindicated. Documentation by the prescriber includes specific risk versus benefit. On 3/25/21 a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Clinical Services were the above information was shared. Prior to exit no further information was provided.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		5/7/21

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F 761	Continued From page 58 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on the observation of 3 medication carts and 2 medication rooms; the facility staff failed to dispose of expired medications for two units. The facility staff failed to dispose of expired medications on the Peach Unit and The Green 300 Unit. The findings included: On 03/23/21 at approximately 2:25 PM an inspection of the Medication Cart on the Peach Unit was made with LPN (Licensed Practical Nurse) #3. Upon visual inspection of the medication cart one Glucagon ER Kit was found	F 761	1. The facility failed to dispose of expired glucagon injectable on the Peach and Green unit medication carts. Expired Glucagon immediately discarded on 3/23/2021. 2. A quality monitoring review will be conducted, by the DON/Designee of the medication of the medication carts and medication rooms. Follow up based on findings. 3. Licensed nursing staff will be educated by DON or Designee regarding the policy for the storage and disposal of expired	

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F 761	Continued From page 59 with an expiration date of 12/2020. LPN #3 stated, "I should have looked in the stat box and called the pharmacy to re-order." On 03/24/21 at approximately 10:13 AM an inspection of the Medication Cart on the Green Unit 300 was conducted with LPN (Licensed Practical Nurse) #4. Upon visual inspection of the medication cart one Glucagon Kit was found with an expiration date of 06/2020. LPN #4 stated, "That's way past due. We need to get a new one." Policy: Facility's Pharmacy Services and Procedures Manual. Policy Title: Storage and Expiration dating of Medications, Biologicals, Syringes and Needles. Effective date: 12/01/07. Last revision date: 10/28/19. Paige 2 reads: Facility should ensure that medications and biologicals that: (1) have an expiration date on the label are stored separate from other medications until destroyed or returned to the pharmacy or supplier. On 3/24/21 at approximately, 3:00 PM a debriefing was conducted with the Facility Administrator, The Regional Director of Clinical Services and with the DON (Director of Nursing) concerning the above issue. No comments were voiced.	F 761	medications/biologicals from the medication carts and medication rooms. Weekly observations will be conducted by the DON/Designee weekly x 6 weeks, to ensure that there are no expired medications present in the medication carts and medication rooms. 4. The results of the Quality Monitoring to be reviewed at monthly QAPI meetings for review, analysis, and further recommendations. 5. Date of Compliance: May 7, 2021	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.	F 773		5/7/21

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F 773	Continued From page 60 (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility's staff failed to promptly notify the physician of laboratory results which fell outside of the clinical range for administration of an antibiotic for 1 of 35 residents (Resident #36), in the survey sample. The findings included: Resident #36 was originally admitted to the facility 12/27/18 and had never been discharged from the facility. The current diagnoses included; mild intellectual disabilities and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/16/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #36's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as required supervision of one person with dressing and independent after set-up with transfers, eating, toileting, personal hygiene and bathing and independent with bed mobility, walking with a walker and locomotion in room. Review of the clinical record revealed on 1/29/21	F 773	1. The facility staff failed to provide prompt notification to the physician of laboratory results for Resident #36. MD notified of lab results on 3/25/2021. Resident not affected. 2. DON/Designee will conduct a quality review of resident labs from the last 30 days to determine if the Physician notified in a timely manner of all lab results. 3. Licensed nursing staff will be educated by the DON/Designee on promptly notifying the physician of lab results. The DON/Designee will conduct random observations of labs to ensure labs are being reported, and addressed weekly for 6 weeks. 4. The results of the quality monitoring, will be reported to the quality assurance committee team monthly for review and analysis. 5. Date of Compliance: May 7, 2021	

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at 5:30 a.m. the following nurse's note "Informed by certified nursing assistant (CNA) that resident hit his room mate with a cane. When resident was asked about incident resident responded that he did not want him in the room. Writer separated the residents until a resolution could be made. Observed with scant amount of blood on floor at bedside and on outer left forearm. Area cleansed and covered with dressing. No complaint of pain or discomfort from either resident at this time".

Further review of the clinical record revealed the following Physician Progress Note dated 1/29/21 at 12:17 p.m., "(name of resident) is seen today per nursing regarding physical altercation with roommate. Per nursing, roommate entered into hallway and informed staff that (name of resident) struck him with a walking cane. Residents immediately separated for safety. (name of resident) is seen today sitting up in chair, seems to be at baseline. No distress. Inquired about incident that occurred earlier this a.m. and resident unable to recall events. Inquired if he recalls striking roommate with his cane and he stated, "No, my cane is gone".

The physician's assessment and plan was as follows; 1. Physical altercation, acute agitation this a.m., with other resident. Struck resident with cane, separated immediately Urinalysis (UA) Culture and Sensitivity (C&S), Labs on Monday.

A urinalysis report was observed on the clinical record as obtained 1/30/21 and reported 1/31/21. The urinalysis was signed by a practitioner on 2/1/21 and an order was given for Nitrofurantoin Monohyd Macro Capsule 100 MG (an antibiotic). Give 1 capsule by mouth two times a day for

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seven days related to a urinary tract infection (UTI). Start Date - 02/02/2021 0900.

Further review of the clinical record on 3/24/21, didn't reveal the C&S report. Licensed Practical Nurse #1 was asked on 3/25/21 to review the clinical record for the C&S report as well. LPN #1 stated the report wasn't on the record but she would retrieve it from the local laboratory for it wasn't obtained through the laboratory which routinely processes their labs and for which the facility's staff has immediate access.

On 3/25/21 at approximately 12:10 p.m., LPN #1 provided the final C&S of the urine report which reveal 15,000 colonies of mixed urogenital flora bacteria, isolated. LPN #1 stated because the laboratory report wasn't on the clinical record with the practitioner's signature on it she couldn't say the practitioner had reviewed the report. LPN #1 further stated resident's are not normally treated with an antibiotic when there there are no signs of a UTI (urgency, increased frequency, burning or pain) and less than 100,000 colonies of bacteria growing. LPN #1 further stated she was out at the time of the lab report therefore; the Director of Nursing and the Assistant Director of Nursing were responsible to follow-up on the laboratory results and use of the antibiotic to treat.

On 3/25/21, at approximately 2:00 p.m. the above information was shared with the Executive Director, the Director of Nursing and the Corporate Consultant. The Director of Nursing stated practitioners don't routinely treat 15,000 colonies of bacteria in the urine with an antibiotic and it appeared the practitioners wasn't aware of the laboratory results.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONSULATE HEALTH CARE OF WINDSOR	23352 COURTHOUSE HIGHWAY WINDSOR, VA 23487

(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 775	Continued From page 63	F 775		
F 775 SS=D	Lab Reports in Record - Lab Name/Address CFR(s): 483.50(a)(2)(iv) §483.50(a)(2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility's staff failed to have laboratory results obtained 1/30/21, on the clinical record for 1 of 35 residents (Resident #36), in the survey sample. The findings included: Resident #36 was originally admitted to the facility 12/27/18 and had never been discharged from the facility. The current diagnoses included; mild intellectual disabilities and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/16/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #36's cognitive abilities for daily decision making were severely impaired. In section"G"(Physical functioning) the resident was coded as required supervision of one person with dressing and independent after set-up with transfers, eating, toileting, personal hygiene and bathing and independent with bed mobility, walking with a walker and locomotion in room. Review of the clinical record revealed on 1/29/21 at 5:30 a.m. the following nurse's note "Informed	F 775	1. The facility failed to have to have final lab results obtained for the clinical record for Resident #36. Lab results obtained on 3/25/2021. Resident not affected. 2. DON/Designee will conduct a quality review of residents' clinical record in the last 30 days to determine if lab results have been filed in the clinical record after they have been addressed by the physician. 3. Medical Records Staff and Licensed Nursing Staff will be educated by the DON/Designee on promptly filing lab results into the residents' clinical record. The DON/Designee will conduct random observations of clinical records to ensure labs are being promptly filed and addressed in the clinical record weekly for 6 weeks. 4. The results of the quality monitoring, will be reported to the quality assurance committee team monthly for review and analysis. 5. Date of Compliance: May 7, 2021	5/7/21

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F 775	Continued From page 64	F 775		

by certified nursing assistant (CNA) that resident hit his room mate with a cane. When resident was asked about incident resident responded that he did not want him in the room. Writer separated the residents until a resolution could be made. Observed with scant amount of blood on floor at bedside and on outer left forearm. Area cleansed and covered with dressing. No complaint of pain or discomfort from either resident at this time".

Further review of the clinical record revealed the following Physician Progress Note dated 1/29/21 at 12:17 p.m., "(name of resident) is seen today per nursing regarding physical altercation with roommate. Per nursing, roommate entered into hallway and informed staff that (name of resident) struck him with a walking cane. Residents immediately separated for safety. (name of resident) is seen today sitting up in chair, seems to be at baseline. No distress. Inquired about incident that occurred earlier this a.m. and resident unable to recall events. Inquired if he recalls striking roommate with his cane and he stated, "No, my cane is gone".

The physician's Assessment and plan was as follows 1. Physical altercation, acute Agitation this a.m. with other resident. Struck resident with cane-separated immediately Urinalysis (UA) Culture and Sensitivity (C&S), Labs on Monday.

A urinalysis report was observed on the clinical record as obtained 1/30/21 and reported 1/31/21. The urinalysis was signed by a practitioner on 2/1/21 and an order was given for Nitrofurantoin Monohyd Macro Capsule 100 MG (an antibiotic). Give 1 capsule by mouth two times a day for seven days related to a urinary tract infection

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F 775	Continued From page 65	F 775		

(UTI). Start Date - 02/02/2021 0900.

Further review of the clinical record on 3/24/21, didn't reveal the C&S report. Licensed Practical Nurse #1 was asked on 3/25/21 to review the clinical record for the C&S report as well. LPN #1 stated the report wasn't on the record but she would retrieve it from the local laboratory for it wasn't obtained through the laboratory which routinely processes their labs and for which the facility's staff has immediate access.

On 3/25/21 at approximately 12:10 p.m., LPN #1 provided the final C&S of the urine report which reveal 15,000 colonies of mixed urogenital flora isolated. LPN #1 stated because the laboratory report wasn't on the clinical record with the practitioner's signature on it she couldn't say the practitioner had reviewed the report. LPN #1 further stated resident's are not normally treated with an antibiotic when there there are no signs of a UTI (urgency, increased frequency, burning or pain) and less than 100,000 colonies growing. LPN #1 further stated she was out at the time of the lab report therefore; the Director of Nursing and the Assistant Director of Nursing were responsible to follow-up on the laboratory results and use of the antibiotic to treat.

On 3/25/21, at approximately 2:00 p.m. the above information was shared with the Executive Director, the Director of Nursing and the Corporate Consultant. The Director of Nursing stated routine lab reports are available on the dashboard but immediate requested labs are process by another entity and the report is faxed to the facility and if the laboratory report is crucial the results are also telephoned to the facility.

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F 881	Continued From page 66	F 881		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, the facility's staff failed to ensure unnecessary administration of an antibiotic for seven days (use of an antibiotic when an infection wasn't diagnosed) for 1 of 35 residents (Resident #36), in the survey sample. The findings included: Resident #36 was originally admitted to the facility 12/27/18 and had never been discharged from the facility. The current diagnoses included; mild intellectual disabilities and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/16/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #36's cognitive abilities for daily decision making were severely impaired. In section "G" (Physical functioning) the resident was coded as required supervision of one person with dressing and independent after set-up with	F 881	1. The facility failed to ensure unnecessary administration of an antibiotic for seven days for Resident #36. Resident not affected. Antibiotic discontinued on 2/8/2021. 2. DON/Designee will conduct a quality review of residents that received antibiotics in the last 30 days to determine if lab results were in clinical range to warrant antibiotic use. Follow up based on findings. 3. Licensed nursing staff will be educated by the DON/Designee on promptly notifying the physician of lab results immediately in order for results to be reviewed to determine if antibiotic warranted. The DON/Designee will conduct random observations of labs to ensure labs are being reported, and addressed weekly x 6 weeks. 4. The results of the quality monitoring, will be reported to the quality assurance	5/7/21

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F 881	Continued From page 67 transfers, eating, toileting, personal hygiene and bathing and independent with bed mobility, walking with a walker and locomotion in room. Review of the clinical record revealed on 1/29/21 at 5:30 a.m. the following nurse's note "Informed by certified nursing assistant (CNA) that resident hit his room mate with a cane. When resident was asked about incident resident responded that he did not want him in the room. Writer separated the residents until a resolution could be made. Observed with scant amount of blood on floor at bedside and on outer left forearm. Area cleansed and covered with dressing. No complaint of pain or discomfort from either resident at this time". Further review of the clinical record revealed the following Physician Progress Note dated 1/29/21 at 12:17 p.m., "(name of resident) is seen today per nursing regarding physical altercation with roommate. Per nursing, roommate entered into hallway and informed staff that (name of resident) struck him with a walking cane. Residents immediately separated for safety. (name of resident) is seen today sitting up in chair, seems to be at baseline. No distress. Inquired about incident that occurred earlier this a.m. and resident unable to recall events. Inquired if he recalls striking roommate with his cane and he stated, "No, my cane is gone". The physician's assessment and plan was as follows; 1. Physical altercation, acute agitation this a.m., with other resident. Struck resident with cane, separated immediately Urinalysis (UA) Culture and Sensitivity (C&S), Labs on Monday. A urinalysis report was observed on the clinical	F 881	committee team monthly for review and analysis. 5. Date of Compliance: May 7, 2021	

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F 881	Continued From page 68	F 881		

record as obtained 1/30/21 and reported 1/31/21. The urinalysis was signed by a practitioner on 2/1/21 and an order was given for Nitrofurantoin Monohyd Macro Capsule 100 MG (an antibiotic). Give 1 capsule by mouth two times a day for seven days related to a urinary tract infection (UTI). Start Date - 02/02/2021 0900.

Further review of the clinical record on 3/24/21, didn't reveal the C&S report. Licensed Practical Nurse #1 was asked on 3/25/21 to review the clinical record for the C&S report as well. LPN #1 stated the report wasn't on the record but she would retrieve it from the local laboratory for it wasn't obtained through the laboratory which routinely processes their labs and for which the facility's staff has immediate access.

On 3/25/21 at approximately 12:10 p.m., LPN #1 provided the final C&S of the urine report which reveal 15,000 colonies of mixed urogenital flora bacteria, isolated. LPN #1 stated because the laboratory report wasn't on the clinical record with the practitioner's signature on it she couldn't say the practitioner had reviewed the report. LPN #1 further stated resident's are not normally treated with an antibiotic when there there are no signs of a UTI (urgency, increased frequency, burning or pain) and less than 100,000 colonies of bacteria growing. LPN #1 further stated she was out at the time of the lab report therefore; the Director of Nursing and the Assistant Director of Nursing were responsible to follow-up on the laboratory results and use of the antibiotic to treat.

Review of the medication administration record revealed Resident #36 received Nitrofurantoin Monohyd Macro Capsule 100 MG (an antibiotic). Give 1 capsule by mouth two times a day for

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F 881	Continued From page 69	F 881		

seven days, as evidenced by licensed nurses signatures.

On 3/25/21, at approximately 2:00 p.m., the above information was shared with the Executive Director, the Director of Nursing and the Corporate Consultant. The Director of Nursing stated practitioners don't routinely treat 15,000 colonies of bacteria in the urine with an antibiotic and it appeared the practitioners wasn't aware of the laboratory results in order to discontinue the ordered antibiotic.

Health care professionals typically test a sample of your urine to diagnose a bladder infection. In rare cases, a health care professional may also order another test to look at your urinary tract.

Lab tests
Urinalysis. You will collect a urine sample in a special container at a doctor's office or at a lab. A health care professional will test the sample for bacteria and white blood cells, which the body produces to fight infection. Bacteria also can be found in the urine of healthy people, so a bladder infection is diagnosed based both on your symptoms and lab tests.

Urine culture. In some cases, a health care professional may culture your urine to find out what type of bacteria is causing the infection. Urine culture is not required in every case, but is important in certain circumstances, such as having repeated UTIs or certain medical conditions. The results of a urine culture take about 2 days to return and will help your health care professional determine the best treatment for you.
(https://www.niddk.nih.gov/health-information/urol

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F 881	Continued From page 70 ogic-diseases/bladder-infection-uti-in-adults/diagnosis) If a urine culture is to be sent, the specimen should be collected before the initiation of antibiotics. While the results of the urine culture are pending, the initiation of antibiotics should be delayed until the results of the culture are available, if possible. This way, therapy can be directed at the specific pathogen(s).2,11 When antibiotics are started empirically, the choice of agent should be reevaluated once culture results are available. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5582677/)	F 881		