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	495422	A. BUILDING _____ B. WING _____	C 10/25/2021

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/12/21 through 10/15/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/12/21 through 10/15/21 and continued on 10/25/2021. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Six complaints, (VA00050166-unsubstantiated, VA00050444-substantiated without deficiency, VA00051256-unsubstantiated, VA00051552-unsubstantiated, VA00052653-substantiated with deficiency, and VA00053298-substantiated with deficiency), were investigated during the survey. The census in this 94 certified bed facility was 84 at the time of the survey. The survey sample consisted of 41 resident reviews.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility	F 554	F554	11/22/21

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

Electronically Signed | 11/12/2021

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F 554	Continued From page 1 documentation and clinical record review the facility staff failed to ensure the Resident was able to self administer medications for 1 Resident (#76) in a survey sample of 41 Residents. The findings included: For Resident #76 facility staff left prescription fluticasone propionate at bedside for two days. On 10/12/21 at approximately 11:30 AM Resident # 76 was observed in bed with head of bed elevated watching TV. On her bedside table were her personal belongings along with a bottle of fluticasone propionate (a prescription cortisone nasal spray). An interview was conducted with Resident # 76 who stated that "the nurse from yesterday left it in here so that I could use it when I was ready." When asked if she used it yesterday she stated she was not sure, but when asked if she used it today she stated no not yet. On 10/12/21 at approximately 11:40 AM an interview was conducted with RN C who was asked if Resident #76 can self-administer medications, she stated that the Resident does not have an order to self-administer. When asked if she had been in the room of Resident #76 she stated that she had not given that Resident her medications yet. RN C was asked to step into the room from the hallway so that she could visualize the bedside table. When asked if that medication should be left at the bedside she stated "no." RN C was asked what are the risks of leaving a medication at the bedside of someone who has not been screened for self-administration, and she stated there is a risk that they might not take	F 554	The medication for Resident #76 was removed from her bedside during the survey and a self-administration of medication assessment completed. All residents are at risk. A quality round was conducted on 10/18/2021 and 10/19/2021 by the facility leadership team to ensure that no Residents without the ability to self-administer medication had medication left at beside with none found. Any resident wishing to self-administer medication is at risk and will have a self-administration assessment completed. Licensed nurses to be educated by the DON/designee on the process for assessing a Resident for the ability to self-administer medication and the requirement to leave no medication at beside without the proper assessment, physician□s orders and plan of care in place. Department managers will be educated by the Administrator/designee as to the need to observe for medication at beside on their concierge rounds and to ensure that it is not present for residents not assessed as being able to self-administer medications. New hires and agency staff will receive these trainings during their orientation. The DON/designee will audit new admission weekly x 4 weeks to ensure that they are being assessed for self-administration of medication. Department managers will document any	

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F 554	Continued From page 2 their meds or that they may forget they took them and take more than the prescribed dosage, On the afternoon of 10/12/21 a review of the clinical record was conducted and the Resident did not have orders to self-administer medications, she did not have it care planned nor was an assessment completed. On 10/13/21 at 10:00 AM an interview was conducted with the DON who was asked if Resident #76 was able to self-administer medications and she stated that she was not. When asked what the expectation is for nurses with regards to leaving medications at the bedside, and she stated that medications are not left at the bedside unless the Resident was screened for self-administration and has a doctors order to do so. On 10/14/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 554	findings and corrective action taken on their concierge round sheets to review daily in standup meetings and turn in weekly to the administrator. The Administrator will review and trend any findings from the concierge round sheets and DON audits and report monthly at the QAPI meeting x 3months for committee input and to ensure compliance with this plan of correction.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family	F 565		11/22/21

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F 565	Continued From page 3 group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, facility documentation review, clinical record review and in the course of a complaint investigation, the facility staff failed to respond to Resident Council grievances for 7 of 41 sampled residents. The findings included: On the afternoon of 10/12/21, Surveyor F met with Resident #42, the Resident Council President and obtained permission for the survey team to review Resident Council Minutes. On 10/13/21, Resident Council minutes were	F 565	F565 The administrator met with the resident council on 10/27/2021 and addressed all questions and concerns presented. All residents are at risk. A quality round was conducted on 10/18/2021 and 10/19/2021 by members of the leadership team. Residents were quarried for any unaddressed concerns with corrective action taken immediately and documented. Staff in all departments to be educated on	

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F 565	Continued From page 4 reviewed from April 2021-Sept. 2021. The minutes revealed ongoing concerns and complaints regarding: ice not being passed, call bells not working, medications being administered late and not being administered as ordered, staff being rude, and lack of care during the night shift. These concerns persisted over the course of 6 months. On 10/13/21, Surveyor F met with the Resident Council. Seven Residents were in attendance (Resident #13, #15, #32, #42, #53, #67, and #68). The Residents verbalized that the same issues and complaints remain with no resolution. On 10/13/21, the facility staff provided the survey team with grievances that were brought forth from the Resident Council which listed each of these concerns. There was evidence of some staff training, but no evidence that all nursing staff were educated on the concerns to facility resolution of the concerns. On 10/13/21, the facility Administrator was made aware of the concern that Resident Council expresses the same concerns for months with no resolution being indicated. The Administrator stated, "I held a special Resident Council with the Residents myself in July, for this very reason". The notes of the council meeting held on 7/28/21, with the facility Administrator revealed that the Residents asked that the Administrator and DON (director of nursing) to attend the next scheduled meeting in August. Review of the meeting minutes from the Resident Council meeting held 8/11/21, revealed that the DON did not attend the meeting as requested by the Resident Council group.	F 565	the process for handling grievances by the Administrator/designee. Department Managers will be educated by Administrator on the process for responding to any concerns regarding their departments voiced during Resident council meetings and the process for documenting their actions and responses and communicating those back to the Resident Council. New hires and agency staff will receive these trainings during their orientation. The Administrator will meet with the Resident Council weekly and review the grievance log x 12 weeks to ensure that all grievances are being addressed in a timely manner and report findings to QAPI monthly x 3 months to ensure compliance with this plan of correction.	

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F 565	Continued From page 5 On 10/14/21, during an end of day meeting the facility Administrator and DON were made aware of the findings. No additional information was received. Complaint Related Deficiency.	F 565		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		11/22/21

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F 657	Continued From page 6 by: Based on interview, clinical record review and facility documentation review the facility staff failed to review and revise the care plans for 1 Residents (#26) in a survey sample of 41 Residents. The findings included: For Resident #26 the facility staff failed to review and revise the care plan to include changes in behavior and the need for 1:1 monitoring. On 10/12/21 at approximately 11:45 AM, Resident #26 was observed in his bed fully dressed asleep. A staff member was sitting in a chair with an over bed table in front of her at the entrance to the room. The staff member identified herself as CNA E and was interviewed at that time. CNA E stated that Resident #26 was placed on 1:1 because of behaviors he had exhibited the previous evening. She stated that he has been hitting staff. When asked has he ever hit other Residents she stated that he did and has been placed on 1:1 in the past for that behavior. On 10/12/21 at 12:20 PM an interview was conducted with the RN Supervisor who stated that Resident #26 has a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment and has been having some behavioral issues that are believed to be the progression of his dementia. She stated the facility has the Resident on 1:1 for the safety of other Residents and staff. The RN Supervisor stated the Psychiatric Nurse Practitioner is looking into changing his medications. A review of the clinical record revealed that the	F 657	F657 The care plan for Resident #26 was reviewed and revised on 11/5/2021 to reflect his current level of supervision requirements. Updates to his level of supervision will occur as needed with changes in his care needs. All residents are at risk. Care plans for current residents will be audited against the last 30 days of risk reports and change of condition reports by Nursing Administration to ensure that updates have occurred as needed with corrective action taken if required. The IDT will be educated by the DON/designee as to the requirements to update care plans with all resident changes to include the need for additional monitoring if required due to an exacerbation of inappropriate behaviors. New hires and/or agency staff will receive these trainings during their orientation. Nursing administration will review incident reports and changes of condition during their morning clinical meetings daily (M-F) and compare with the Resident's care plan to ensure that revisions are made timely. The DON will report findings to the QAPI committee monthly x3 months for additional recommendations and compliance with this plan of correction.	

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F 657	Continued From page 7 facility did reach out to Psychiatric services and they are indeed looking into his medications and any changes that might benefit the Resident. The Resident was discharged from talk therapy as he is unable to effectively participate. On 10/13/21 at approximately 11:00 AM an interview was conducted with the social worker who stated that Resident #26's behaviors have been discussed with the RP and with the doctors, and the facility is keeping him on 1:1 for safety. When asked if this was discussed in the care plan meeting she stated that it was. On 10/13/21 a review of the clinical record revealed that Resident # 26's care plan had not been revised to include 1:1 monitoring for behaviors. On 10/13/21 at 1:00 PM an interview was conducted with the DON. The DON was asked what the purpose of revising the care plan and she stated the care plan is how the nurses know what care the Resident needs. When asked how often should the care plan be updated and she stated that the care plan should be updated quarterly and with any significant changes in condition or treatment. When asked if the 1:1 for behaviors should be listed on the care plan she stated that it should. On 10/14/21 the Administrator was made aware of the issues and no further information was provided.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		11/22/21

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F 658	Continued From page 8 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to provide care that meets professional standards of quality for 1 Resident (#178) in a survey sample of 41 Residents. The findings include: 1a. For Resident #178 the facility staff failed to administer medications as ordered by physician and failed to use saline flush to keep picc line patent. A review of the clinical record revealed that Resident #178 was admitted to the facility on 8/12/21 at 8 PM, after having been hospitalized and had surgery for necrotizing fasciitis (also known as flesh eating bacteria) to her inner thigh. Among Resident # 178's discharge summary were orders for the following medications: Clindamycin 300 mg one capsule every six hours (an antibiotic). -A review of the MAR (Medication Administration Record) revealed that Resident #178 did not receive 5 doses of this medication - A review of the progress notes revealed that nurses documented medication was unavailable. A review of the stat box contents revealed this medication was available in the stat box. Gabapentin 600 mg 1 tablet three times a day for neuropathic pain-A review of the MAR revealed the resident missed nine doses of gabapentin. A	F 658	F658 Resident #178 was discharged prior to the survey. All residents are at risk. Current resident orders and medication inventories were reviewed on 10/19/2021 and 10/22/2021 by the ADON/designee to ensure that medications were being administered as ordered with corrective action taken as needed. ADON reviewed any current residents with a PICC line to ensure orders for flushes are done. The Omnicell inventory was reviewed on 10/25/2021 by the Administrator/ADON and Attending Physicians with recommendations made to the contracted pharmacy for changes to better promote availability based on actual in-house resident needs. Adjustments to the available inventory were made on 10/26/2021 by Pharmacy personnel. Licensed nurses to be educated by DON/designee on professional standards of practice to include adherence to physician□s orders for administration of medications and treatments (pic line flushes) as well as steps to take to obtain needed medications from the pharmacy or stat supplies. New hires and agency	

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F 658	Continued From page 9 review of the progress notes revealed the nurses documented medication unavailable awaiting from pharmacy. A review of the Stat Box contents revealed the medication was available in the stat box in a lower dose strength (300 mg) Oxycodone 10 mg tablet immediate release one tablet every six hours as needed for pain. This pain medication was not administered until 8/14/21 this medication also was available in the stat box. On the morning of 10/14/21 an interview was conducted with Employee H (the pharmacist) who stated that the staff could have taken the medications from the stat box as several of the medications were in the stat box. When asked if the Resident had an order for Neurontin 600 mg and you only had the 300 mg tabs could you use two of them, she stated it is possible if you first notify the physician and get an order to give 2 of the 300 mg tabs until the 600 mg tabs arrive. She also stated "The facility has the ability to reach out to us to get a prescription from our backup pharmacy." Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Mosby's/ Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing Scope and Standards of Nursing Practice of (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following:	F 658	staff will receive these trainings during their orientation. Nursing administration will monitor reports from the electronic medical record daily for omissions during their morning clinical meeting daily (M-F) daily with immediate corrective action take as required. The DON/designee will track/trend findings from these morning reviews and report monthly to QAPI x 3 months for additional recommendations and to ensure compliance with this plan of correction.	

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F 658	Continued From page 10 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation. 1b) The facility staff also failed to flush the picc line from admission on 8/12/21 until 8/15/21. The order for the flush read to flush before and after medication administration of IV antibiotics, however the IV antibiotics did not get to the facility until 8/15/21. They did not clarify the order with the MD to get an order for flushing to keep line patent. https://journals.lww.com/nursing/Citation/2007/09000/What_you_need_to_know_about_PICCs,_part_2.14: Lippencott online read: "To maintain catheter patency, flush the picc every 12 to 24 hours when it's not in use and before and after any infusions. Infusion Nurses Society standards recommend that the minimum flush volume be at least twice the volume capacity of the catheter and add-on devices." On 10/13/21 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.	F 658		

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F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility record review the facility staff failed to provide adequate services to maintain good personal hygiene for 4 Residents (#26, #32, # 65, and #76) in a survey sample of 41 Residents. The findings included: 1. For Resident #26 the facility staff failed to provide routine bathing necessary to maintain proper hygiene. On 10/12/21 at approximately 11:45 AM, Resident #26 was observed in his bed fully dressed asleep. A staff member was sitting in a chair with an over bed table in front of her at the entrance to the room. 10/13/21 at approximately 9:45 AM the Resident was observed sitting in the area in front of the nurse's station with a staff member CNA E sitting beside him. The Resident was dozing in his chair. On 10/13/21 at 3 PM an interview was conducted with CNA E who was asked how often Residents get showered and she stated they showered 2 times a week. When asked what they do if a Resident refuses she stated that they document it on POC (Point of Care computerized charting for	F 677	F677 Residents #26, 32, 65 and 76 were offered showers with the Unit Manager following up to ensure that ADL care/grooming occurred or refusal was documented. Administrator made night rounds on 10/21/2021 and addressed Resident #32□s concern. All residents are at risk. A quality round was conducted on 10/18/2021 and 10/19/2021 by the facility leadership team to observe and query residents on their shower/groom needs with corrective action taken as required. The Administrator and HR Director made night quality rounds on 10/21/2021 to observe resident grooming and ADL care. No concerns were identified. Nursing administration audited 2 weeks of shower records and queried interviewable residents as to reasons for refusals and address. Nursing staff to be educated by the DON/designee on the requirement to provide ADL care to dependent residents to include offering and documenting 2 showers per week or management and documenting of refusals of said showers.	11/22/21

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F 677	Continued From page 12 CNA's) and they notify the charge nurse. On 10/13/21 during clinical record review it was discovered during the period of time from 9/22/21 until 10/13/21 Resident #26 received 1 shower and 2 bed baths. On 9/22/21 he received a shower and on 10/6/21 and 10/7/21 he received a bed bath. There were no refusals documented on POC for Resident #26. The review showed that Resident #26 has a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment and he is unable to bathe without assistance. The facility provided their policy on ADL care excerpts are as follows: "Policy - AM Care" "Morning care will be offered each day to promote resident comfort, cleanliness, grooming, and general wellbeing. Residents who are capable of performing their own personal care are encouraged to do so but will be provided with setup assistance if needed. Showers and baths are scheduled three times weekly or more or less often according resident preference." "Policy: PM Care" "Nursing staff will offer evening/PM care to residents to promote personal hygiene, comfort, relaxation and safety. Residents who are capable of performing their own care are encouraged to do so, with assistance as needed. PM care may be performed at the bedside or in the bathroom, according to resident preference." On 10/14/21 during the end of day meeting the Administrator was made aware of the concerns	F 677	Department managers will be educated by the Administrator/designee as to the need to observe for proper ADL care of dependent residents on their concierge rounds and to ensure that corrective action is taken immediately as needed. New hires and agency staff will receive these trainings during their orientation. In addition, the unit manager/designee will report the scheduled showers each day in the morning standup meeting so that managers are aware of the schedule and able to assist in monitoring compliance with the schedule. Department managers will document any findings and corrective action taken on their daily concierge round sheets and turn in weekly to the administrator for trending. Nursing administration will check the documentation of the prior days ADL care during their morning meeting and follow-up on any refusals or omissions. The DON will trend any findings from the morning meeting and the administrator will trend concierge round sheets and report monthly at the QAPI meeting x 3months for committee input and to ensure compliance with this plan of correction.	

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and no further information was provided.

2. For Resident # 32 the facility staff failed to provide routine and necessary incontinent care for dependent residents.

A record review show that Resident #32 most recent MDS (Minimum Data Set) dated 8/17/21 coded the Resident as unable to stand and bear weight and 4. total dependence on staff for all aspects of ADL care.

On 10/12/21 at approximately 11:55 AM Resident #32 was observed sitting in his room in his wheelchair watching TV. An interview was conducted at that time, and Resident #32 stated that night shift does not do rounds and check if he needed to be changed. Resident #32 is unable to walk and is incontinent of bowel and bladder. The Resident stated that they (the Residents) have all complained about it in Resident council. Resident #32 stated that the facility is well aware of the situation and that the Resident has filed a grievance about the staff not answering call bells in a timely manner.

"Documentation of facility follow up: CNA's were educated on answering the call lights in a timely manner."
[Signed by RN Supervisor on 6/29/21]

Review of Resident Council minutes revealed that in July, Aug and Sept the Residents complained "staff during the night do not check on Residents, or provide care they are sleeping in their cars."

On 10/13/21 the Administrator was asked about the concern form from Resident #32 and she

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stated that they have a lot of agency staff primarily working the evening and night shift (7 pm - 7 am). She stated that they have had complaints about the staff not making rounds and answering call lights, however they have been educated on the importance of answering lights in a timely manner.

On 10/14/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

3. For Resident #65 the facility staff failed to provide routine bathing necessary to maintain proper hygiene.

A record review showed that Resident #65 had a BIMS (Brief Interview of Mental Status) score of 5 indicating severe cognitive impairment and was not able to bathe without assistance.

On 10/12/21 at approximately 11:20 AM Resident #65 was observed laying in his bed dressed in a hospital gown and brief, asleep.

On 10/12/21 at approximately 2:30 PM Resident #65 was observed in his bed wearing a hospital gown watching TV. An attempt to interview the Resident was made but due to his cognitive status he was unable to follow or answer appropriately.

On 10/13/21 at 3:00 PM an interview was conducted with CNA E who was asked how often Residents get showered and she stated they showered 2 times a week. When asked what they do if a Resident refuses she stated that they document it on POC (Point of Care computerized

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charting for CNA's) and they notify the charge nurse.

On 10/13/21 during clinical record review it was discovered that Resident #65 had the following bed baths (no showers) during the period of time between 9/17/21 and 10/13/21:

9/17/21 at 3:37 AM
9/18/21 at 3:42 AM
9/28/21 at 12:24 PM
10/1/21 at 3:14 PM
10/11/21 at 2:52 PM
10/12/21 at 12:37 PM

There were no refusals of showers documented on POC for Resident #65.

On 10/14/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

4. For Resident #76 the facility staff failed to provide routine bathing and hair washing necessary to maintain proper hygiene.

A record review showed that Resident #7 was unable to stand and bear weight and her most recent MDS 9/27/21 coded the Resident as 3. requiring extensive assistance with ADL care.

On 10/12/21 at approximately 11:30 AM Resident #76 was observed in her room in her bed with head of bed elevated, watching TV dressed in a hospital gown the Resident had food stains on her gown and hair was uncombed and appeared oily. An interview was conducted with Resident #76 at that time. When asked about showering

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the Resident stated "Honey I have not been out of this bed in 2 whole years." When asked how she bathes she stated the CNA's sponge bathe her and when asked about washing her hair she stated that the CNA's use dry shampoo spray, and they use the spray leave in conditioner.

A review of the POC documentation revealed that Resident #76 had 1 Refusal of a bath on 9/20/21. She received the following bed baths (no showers) for the period of 9/13/21 through 10/13/21:

9/22/21 at 6:59 PM
10/6/21 at 6:14 PM
10/7/21 at 3:33 PM

On 10/13/21 at 3 PM an interview was conducted with CNA E who was asked how often Residents get showered and she stated they showered 2 times a week. When asked what they do if a Resident refuses she stated that they document it on POC (Point of Care computerized charting for CNA's) and they notify the charge nurse.

The facility provided their policy on ADL care excerpts are as follows:

"Policy - AM Care"
"Morning care will be offered each day to promote resident comfort, cleanliness, grooming, and general wellbeing. Residents who are capable of performing their own personal care are encouraged to do so but will be provided with setup assistance if needed. Showers and baths are scheduled three times weekly or more or less often according resident preference."

"Policy: PM Care"

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F 677	Continued From page 17 "Nursing staff will offer evening/PM care to residents to promote personal hygiene, comfort, relaxation and safety. Residents who are capable of performing their own care are encouraged to do so, with assistance as needed. PM care may be performed at the bedside or in the bathroom, according to resident preference." On 10/14/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide oxygen therapy consistent with infection control measures for 2 Residents, Resident #70 and Resident #6, in a survey sample of 41 Residents. The findings included: 1. For Resident #70, facility staff failed to change the oxygen tubing weekly as ordered. During initial tour on 10/12/21 at approximately	F 695	F695 The oxygen tubing for Resident #70 and Resident #6 was changed and dated during the survey. The oxygen tubing for all Residents requiring oxygen was changed on 10/24/2021. Licensed nurses will be educated by the DON/designee as to the requirement for oxygen tubing to be changed weekly and dated to substantiate that the change has	11/22/21

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F 695	Continued From page 18 11:30 AM, Surveyor D observed Resident #70 with oxygen being administered via nasal cannula at 1 liter per minute as ordered by the physician. There was no date on the oxygen tubing. Surveyor D conducted an interview with RN C at the bedside of Resident #70. RN C confirmed the observation stating, "No, I do not see any date on the [oxygen] tubing, typically it is changed weekly on night shift". When asked about the importance of changing the oxygen tubing weekly, RN C stated, "It needs to be changed weekly to prevent the spread of infections". Review of Resident #70's clinical record revealed a physician's order that read, "Change any O2 [oxygen] tubing weekly on Sunday and PRN [as needed]". Review of the facility's policy entitled, "Oxygen Administration Policy", revision date 12/16/19, subheading "Cleaning", read, "Change tubing, mask, and cannula weekly and document". The Facility Administrator was informed of the findings. No further information was provided. 2. For Resident #6, facility staff failed to change the oxygen tubing weekly as ordered. During initial tour on 10/12/21 at approximately 1:30 PM, Surveyor F observed Resident #6 with oxygen being administered via nasal cannula at 2 liters per minute as ordered by the physician. There was no date on the oxygen tubing. Review of Resident #6's clinical record revealed a	F 695	occurred. Department Managers will be educated by the Administrator/designee as to the facility schedule for changing oxygen tubing and the need for monitoring this on their concierge rounds and documenting any concerns they identify and corrective action take on their rounds sheets. New hires and agency staff will receive these trainings during their orientation. Daily concierge round sheets will be turned in weekly to the administrator for review and follow-up as needed. The Administrator will report trends from the Concierge Round Sheets monthly x 3 months to the QAPI committee for further recommendations and to ensure compliance with this plan of correction.	

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F 695	Continued From page 19 physician's order that read, "Change any O2 [oxygen] tubing weekly on Sunday and PRN [as needed]". Review of the facility's policy entitled, "Oxygen Administration Policy", revision date 12/16/19, subheading "Cleaning", read, "Change tubing, mask, and cannula weekly and document". The Facility Administrator was informed of the findings. No further information was provided. No further information was provided.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review, facility documentation and clinical record review the facility staff failed to ensure adequate pain management for 1 of 41 sampled residents (Resident #178). The findings included: For Resident #178 the facility staff did not administer pain medication although it was available in the stat box. A review of the clinical record revealed that Resident #178 was admitted to the facility on	F 697	F697 Resident #178 was discharged prior to the survey. All residents are at risk. All resident medication inventories and orders were reviewed on 10/19/2021 and 10/22/2021 by the ADON/designee to ensure that medications were available and being administered as ordered with corrective action taken as needed. The Omnicell inventory was reviewed on	11/22/21

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F 697	Continued From page 20 8/12/21 at 8 PM, after having been hospitalized and had surgery for necrotizing fasciitis (also known as flesh eating bacteria) to her inner thigh. Among Resident # 178's discharge summary were orders for the following medications: Gabapentin 600 mg 1 tablet three times a day for neuropathic pain. A review of the MAR revealed the resident missed nine doses of gabapentin. Oxycodone 10 mg tablet immediate release one tablet every six hours as needed for pain. This pain medication was not administered until 8/14/21. A review of the progress notes revealed the nurses documented Gabapentin was unavailable awaiting from pharmacy. A review of the Stat Box contents revealed the Gabapentin was available in the stat box in a lower dose strength of 300 mg. A review of the Stat Box contents revealed Oxycodone was available in the stat box. A review of the care plan reveals the Resident has care plan for potential for pain the interventions read: "Administer pharmacological interventions as indicated per physician and monitor the effectiveness Date Initiated: 08/13/2021" A review of the clinical record revealed the following excerpt from the Nurse Practitioner's progress note: "8/13/21 at 2:45 PM -The patient is seen in her room today morning [sic]. She reports right groin and thigh pain at a level of 9/10 since the patient	F 697	10/25/2021 by the Administrator/DON and Attending Physicians with recommendations made to the contracted pharmacy for changes to better promote availability based on actual in-house resident needs. Adjustments to the available inventory were made on 10/26/2021 by Pharmacy personnel. Licensed nurses to be educated by DON/designee on the requirement to manage pain to include adherence to physician□s orders for administration of pain medications as well as steps to take to obtain needed medications from the pharmacy or stat supplies. New hires and agency staff will receive these trainings during their orientation. Nursing administration will monitor reports from the electronic medical record daily (Monday through Friday) for any concerns related to resident pain or medication administration/availability during their morning clinical meeting with immediate corrective action take as required. The DON/designee will track/trend findings from these reviews and report monthly x 3months to QAPI for additional input and to ensure compliance with this plan of correction.	

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has not received her oxycodone p.r.n. The patient reports she uses oxycodone at home chronically for her arthritis and she also reports she is needing Dilaudid prior to application of the wound VAC due to significant pain at the site."

A review of the MAR revealed that Resident #178 was not given her PRN Oxycodone until 8/14/21 at 12:08 PM

On 10/13/21 at approximately 11:25 AM an interview was conducted with the DON who was stated the Pharmacy makes two runs a day. She stated that come in the middle of the night and in the middle of the day. When asked how long it takes to get orders in the system for a new admission she stated that it takes about 2 hours. When asked what the cutoff time to get the medications on the next run she stated it is at 11:30 PM. She further stated that Resident #178 should have had her medications in the middle of the night run. When asked if there is a backup pharmacy she stated that there was a backup pharmacy.

On the morning of 10/14/21 an interview was conducted with Employee H (the pharmacist) who stated that the staff could have taken the medications from the stat box as several of the medications were in the stat box. When asked if the Resident had an order for Neurontin 600 mg and you only had the 300 mg tabs could you use two of them, she stated it is possible if you first notify the physician and get an order to give 2 of the 300 mg tabs until the 600 mg tabs arrive. She also stated "The facility has the ability to reach out to us to get a prescription from our backup pharmacy."

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F 697	Continued From page 22 On 10/14/21 the DON provided the "Proof of Delivery" statement from the pharmacy which listed the medications that were delivered on 8/13/21. Among the medications delivered on that day were the Gabapentin and the Oxycodone. When asked why the medications were documented as not administered if they were in the facility, and she stated that she did not know. On 10/14/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		11/22/21

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F 755	Continued From page 23 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to ensure availability of medications for 1 Resident (#24) in a survey sample of 41 Residents. The findings include: For Resident #24, the facility staff failed to provide medications as ordered by the Physician. On 10/12/21 at 05:01 PM, Resident #24 stated, "I have pain all over my body, I'm eat up with arthritis, they only give me Tylenol". On 10/13/21, a review of Resident #24's clinical record was conducted. This review revealed the following nursing notes: 9/21/21- Gabapentin Capsule 400 MG, "Awaiting medication from pharmacy". 10/4/21- Famotidine Tablet 20 MG, "unavailable to administer, reordered". 10/12/21-Gabapentin Capsule 400 MG, "Awaiting arrival". 10/12/21-Vitamin D3 Tablet, "on order". According to the September and October 2021 MAR (Medication Administration Record), the	F 755	F755 The ADON audited Resident #24s medication inventory on 10/18/2021 to ensure availability of all ordered medications. All residents are at risk. The ADON/designee audited all Residents medication inventories on 10/18/2021 and 10/22/2021 to ensure availability of all ordered medications with corrective action take as needed. The Pharmacy Team will complete a MAR to cart audit of all medication on or before 11/10/2021 to further ensure that medication inventories are complete for all residents. The Omnicell inventory was reviewed on 10/25/2021 by the Administrator/DON and Attending Physicians with recommendations made to the contracted pharmacy for changes to better promote availability based on actual in-house resident needs. Adjustments to the available inventory were made on 10/26/2021 by Pharmacy personnel. Licensed nurses to be educated by	

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F 755	Continued From page 24 medications were not administered to Resident #24 as listed above. Review of Omnicell (on-site emergency medication stock) contents list revealed the following: Gabapentin Capsule 400 MG -Quantity: 5 in inventory On 10/13/21, the "Controlled Medication Utilization Record" forms for Resident #24's Gabapentin were reviewed. This revealed that Resident #76's Gabapentin 400 mg capsules were received at the facility on 9/30/21, with the last dose given 10/12/21 at 2 PM. The next supply of Gabapentin was not received at the facility until 10/13/21. There were valid Physicians Orders for the medications listed as unavailable. On 10/14/21 at 1:37 PM, an interview was conducted with the DON (Director of Nursing). The DON stated, "if meds (medications) are not available staff are to try to get them out of the Omnicell (in-house stock of medications), if they can't they are to call the pharmacy and physician. The DON confirmed the process for reordering medications, which she said, "there are several options, and you can press the reorder button in the computer or call the pharmacy". When asked when meds are to be ordered, the DON said, "When meds get down to a 7 day supply we will go ahead and order them to prevent them from running out". The DON stated the risks of not receiving Gabapentin as ordered is, "rebound pain, especially with nerve pain". On 10/15/21 at 11:30 AM, a telephone interview	F 755	DON/designee on steps to take to obtain needed medications from the pharmacy. New hires and agency staff will receive these trainings during their orientation. The ADON was educated by the Pharmacy General Manager on 10/26/2021 as to the ability to monitor medication refill needs via the Omnivue webpage and to make refill requests directly via that cite. The ADON/designee will monitor this page a minimum of twice weekly and input refill requests for all medications showing due within the following 5 days. The pharmacy staff will make daily calls to the Administrator/ADON to ensure communication and resolution of any barriers to obtaining required medications. Nursing administration will monitor reports from the electronic medical record daily for issues related to medication availability during their morning clinical meeting with immediate corrective action take as required. The DON/designee will trend/track findings from these reviews and report to the QAPI committee monthly x 3 months to monitor for compliance with this plan of correction	

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was conducted with Other Staff B, the pharmacist. Other Staff B stated, the pharmacy makes 2 deliveries to the facility daily and also has a local retail pharmacy that can be used for back-up if medications are not available and are not in the Omnicell [emergency box of medications maintained on-site]. When asked about cut off times, she stated, "if a medication is ordered before 11:30 PM, we have it on the delivery that comes that night, same for the day delivery, as long as we get it [the order/refill request] about an hour to 30 minutes before we leave the pharmacy with the delivery, it can be included in that delivery".

A review of the facilities policy Entitled medication shortages/unavailable medications page 1 read:

"3. if a medication shortage is discovered after normal pharmacy hours:
3.1 A licensed facility nurse should obtain the ordered medication from the emergency medication supply
3.2 If the ordered medication is not available in the emergency medication supply, the licensed facility nurse should call the pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action.
Action may include:
3.2.1 Emergency delivery; or,
3.2.2 Use of emergency (back up) third-party pharmacy.
4. If an emergency delivery is unavailable, facility nurses should contact the attending physician to obtain orders or directions.
5. Get the medication is unavailable from pharmacy or a third-party pharmacy, and cannot be supplied from the manufacturer, facility should

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F 755	Continued From page 26 obtain alternate physician/prescriber orders, as necessary. 7. If the facility nurse is unable to obtain a response from the attending position/prescriber in a timely manner, the facility nurse should notify the nursing supervisor and contact the medical Director for orders/direction making sure to explain the circumstances of the medication shortage. 8. When I missed doses, an unavoidable facility nurse should document the missed dose and the explanation for the misters on the bar or the tour and in the nurse's notes per facility policy. Such documentation should include the following information: 8.1 A description of the circumstances of the medication shortage; 8.2 And description of pharmacy's response upon notification; and 8.3 actions taken." On 10/14/21, during the end of day debriefing, the Administrator and DON (Director of Nursing) were notified of the issue. No further information was provided.	F 755		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure Residents were free from significant	F 760	F760 Resident #178 was discharged prior to the survey. Residents #24□, #40 and #62's medication inventories and documentation	11/22/21

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F 760	Continued From page 27 medication errors for four Residents (Resident #40, #24, #178, and #62) in a survey sample of 41 Residents, which resulted in harm for Resident #40. The findings included: 1. For Resident #40, the facility staff failed to follow physician orders and provide an anticonvulsant (seizure medication) as ordered, which resulted in Resident #40 having a seizure and being sent to the hospital, this constituted harm. On 10/12/21 at 2:10 PM, the family member/Resident Representative of Resident #40 met with the survey team. She shared concern that Resident #40 had been hospitalized and during the course of her hospital stay had seizures. Resident #40 was started on seizure medication, Keppra while in the hospital. She stated that upon Resident #40's return to the facility the facility staff failed to administer this medication. Resident #40 had another seizure and had to be sent to the hospital. On 10/13/21 and 10/14/21, a review of the EHR (electronic health record) for Resident #40 was conducted. This review revealed that on 8/7/21, Resident #40 was hospitalized and returned to the facility on 8/16/21. Review of the EHR further revealed that hospital records from the hospitalization were in the record. Included in the hospital documents was a neurology consult dated 8/13/21, that read, "While undergoing a investigations, yesterday evening, she had brief generalized tonicclonic seizure with loss of consciousness lasted less	F 760	were reviewed by the ADON on 10/19/2021 to ensure medication availability and administration. All residents are at risk. Current resident orders and medication inventories were reviewed on 10/19/2021 and 10/22/2021 by the ADON to ensure that medications were available and being administered as ordered with corrective action taken as needed. A comparison of orders from the transferring entity to facility orders for any current resident admitted/readmitted in the last 30 days will be conducted by the DON/designee with any discrepancies reviewed with the facility attending physicians for clarification. Licensed nurses will be educated by the DON/designee regarding the process for confirming admission/readmission orders, the requirements to follow all MD orders and the process for handling any medication error including the process for obtaining unavailable medications. New hires and agency staff will receive these trainings during their orientation. Nursing Administration will review the medication administration variance reports from the electronic medical record along with medication risk reports daily in their clinical meeting and take immediate corrective action as required. The DON/designee will track/trending the findings from these reviews and report monthly to QAPI for additional input and to ensure compliance with this plan of	

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than 2 min.. Patient had mild facial droop. She had a CT scan of brain which was reported unremarkable. She does not have fever or new focal neurological deficit she is back to her baseline. She was started on levetiracetam and doing very well. We are unable to do MRI brain due to Permanent pacemaker".

A hospital note dated 8/14/21 and 8/15/21, titled "General Progress Note", both read "On 8/12/21, patient with new onset seizure activity; CT evaluation negative for etiology. Cannot get MRI due to PPM [permanent pacemaker]". Additional notes in this same document read, "She had a brief generalized seizure on 08/12 in the absence of a seizure history. There was noticeable left arm weakness subsequently and a stroke alert was called. There was no CT evidence of bleeding or infarction, and CTA did not reveal evidence of a flow limiting lesion. Neuro interventionalist did not feel that further investigation or treatment was warranted at this time. Local neurology consultation was recommended related to the new onset seizure. She had a 2nd brief seizure after arrival to the ICU but none since. She has been loaded with Keppra and will continue that b.i.d. [twice daily] Unable to get MRI due to pacemaker Keppra 500mg BID, check Keppra level on 8/16, seizure precautions".

The hospital discharge summary dated 8/16/21, noted diagnosis to include: "active problem....seizure". This discharge summary went on to note: "take these medications:....levETIRAcetam 100 MG/ML solution
500 mg, Oral, 2 times daily, commonly known as: KEPPRA". "Hospital course.....Seizure She had a

corrections.

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brief generalized seizure on 08/12 in the absence of a seizure history. There was noticeable left arm weakness subsequently and a stroke alert was called. There was no CT evidence of bleeding or infarction, and CTA did not reveal evidence of a flow limiting lesion. Neuro interventionalist did not feel that further investigation or treatment was warranted at this time. Local neurology consultation was recommended related to the new onset seizure. She had a 2nd brief seizure after arrival to the ICU but none since. She has been loaded with Keppra and will continue that b.i.d. Unable to get MRI due to pacemaker".

Review of Resident #40's physician orders and MAR (medication administration record) for August and September 2021, revealed that she was not ordered or administered Keppra until 9/6/21. There were multiple notes from the providers (doctor and nurse practitioner) of seeing Resident #40 from 8/16/21-9/6/21, and none of the notes made reference to the seizure activity she had in the hospital or the orders for Keppra.

On 9/5/21 at 3 PM, there was a nursing note entry that read, "Resident's daughter noted to be in the hallway yelling for help. This Nurse, other Nurse and Aide arrived at Resident's room where Resident's daughter stated that Resident "had a seizure". Upon assessment of Resident she was noted to be unresponsive to verbal stimulation and slightly responsive to painful stimuli, with her eyes open; VS [vital signs] 112/58 [blood pressure reading], 69 [pulse], 20 [respirations], O2 88% [oxygen saturation] on 2 LPM [2 liters of oxygen per minute]. Resident was unresponsive for 3 minutes. No further seizure like activity

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noted. On call [Nurse Practitioner name redacted] made aware and gave N.O. [new order] Send Resident to ER [emergency room] for eval [evaluation] and tx [treatment]. Resident and RP [responsible person] made aware.

On 9/8/21, there was a progress note written by the nurse practitioner that read, "Upon review of previous d/c [discharge] summary, it appears pt [patient] possibly had seizure like activity at that time and was discharged with recommendation for keppra, which was somehow overlooked".

On 10/13/21, the Director of Nursing provided a document dated 9/6/21, titled "Medication Error" that read, "Upon admission on 8/16/21 Keppra order not transcribed to EMAR (electronic medication administration record). Also provided was a copy of an "IDT (interdisciplinary team) Meeting Progress Note" dated 9/10/21, that read, "Resident readmitted to facility and Keppra omitted from active meds".

On 10/14/21 at 2:10 PM, a telephone interview was conducted with Employee F, the Nurse Practitioner. Employee F was asked if she would ever not agree to an order from the hospital for a Resident to be on Keppra. Employee F stated, "No, we absolutely would order that". Employee F was asked about the details of Resident #40 not receiving Keppra as ordered by the hospital following her having 2 seizures while in ICU (intensive care unit) at the hospital. Employee F stated, "It could have been prevented, I do carry some fault in that. All of it could have been avoided".

On 10/14/21 at approximately 3:50 PM, an interview was conducted with LPN C, who was

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the admitting nurse when Resident #40 returned to the facility on 8/16/21. LPN C stated she had received report from the hospital as well as discharge paperwork. She assessed Resident #40 then called the NP (nurse practitioner) and reviewed the hospital records and orders. LPN C stated she told the NP of the seizure activity in the hospital and was advised to "leave it as is" and she [the NP] would review them when she came in the next day. LPN C very emotionally said "I would never hurt her, I'm so sorry" [referring to Resident #40].

On 10/14/21 at 4:31 PM, the facility Administrator stated their contracted medical provider for physician services "has a phone system that tracks phone calls". She then provided an email that indicated the medical provider received a call from the facility staff on 8/16/21 at 1:51 PM.

On 10/15/21, the Administrator returned to the conference room and had obtained the recording of the conversation between facility staff and the medical provider regarding Resident #40's readmission to the facility. Surveyors D & F listened to the conversation which was between LPN C and Employee F. During this call Employee F, the nurse practitioner stated, ""go ahead and start whatever their changes are [the hospital orders], that's fine. I'll look at them tomorrow when I'm in there, we will request their [the hospital] records. Obviously they would have had neurology [evaluation] and I'm curious what they think happened".

On 10/15/21 at 11:30 AM, a telephone interview was conducted with Other Staff B, the pharmacist. Other Staff B stated, "Keppra is a central nervous system anticonvulsant, the side

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effects would be allergy or adverse reaction history or excessive sedation, which can be controlled by dose adjustments. If someone has had a seizure I don't know why it wouldn't be given unless they were on another medication for this and it would be duplicate therapy".

On 10/15/21 at 9:44 AM, an interview was conducted with the Director of Nursing. She was asked what constitutes a medication error, she stated, "If a medication is not available, given in error or isn't given".

The facility policy titled "Medication Related Errors" read, "4. Administration Errors: In the event of an administration error, facility staff should follow facility policy relating to the medication administration errors.....4.9 Omission Error: Facility fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of recognized contraindication".

On 10/15/21, the facility Administrator was notified of Resident #40 not receiving her seizure medication, which resulted in a seizure and hospital visit constituting harm.

No further information was provided.

2. For Resident #24 the facility staff failed to administer an anticoagulant (blood thinner) for 3 of 4 doses scheduled in a 48 hour time frame, this is a significant medication error.

On 10/13/21-10/14/21, a review of Resident #24's EHR (electronic health record) was conducted.

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Resident #24 was noted to have a diagnosis of paroxysmal atrial fibrillation. Physician orders revealed an order dated 8/9/21, that read, "Brilinta Tablet 90 MG (Ticagrelor) Give 1 tablet by mouth two times a day for Blood thinner." This order was still active.

Review of Resident #24's MAR for October revealed that on 10/4 the 8:30 AM dose was not given and had a code 19 in the block. On 10/5/21, neither of the 2 scheduled doses were administered and both had a code 19 in the block. The last page of the MAR had a legend that indicated, "19=Other / See Nurse Notes". Review of the nursing notes for these 2 days read, "Brilinta Tablet 90 MG, Give 1 tablet by mouth two times a day for Blood thinner unavailable", "Brilinta Tablet 90 MG, Give 1 tablet by mouth two times a day for Blood thinner not in cart", and "Brilinta Tablet 90 MG, Give 1 tablet by mouth two times a day for Blood thinner on order".

On 10/13/21, RN D was asked to verify that Resident #24's medication Brilinta was available. At the medication cart RN D was able to verify that Brilinta was currently in stock. She was asked about the notes on 10/4 & 10/5, and why the medication was not given, and she said "it says it wasn't available". RN D confirmed that the process is that the staff would order medications several days before running out to ensure the pharmacy had time to deliver a refill.

On 10/14/21 at 1:37 PM, an interview was conducted with the DON (Director of Nursing). The DON stated, "if meds (medications) are not available staff are to try to get them out of the Omnicell (in-house stock of medications), if they

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can't they are to call the pharmacy and physician. The DON confirmed the process for reordering medications, which she said, "there are several options, you can press the reorder button in the computer or call the pharmacy". When asked when meds are to be ordered, the DON said, "when meds get down to a 7 day supply we will go ahead and order them to prevent them from running out". The DON stated the risks of not receiving blood thinners as ordered is, "they run the risk of getting a blood clot, which could cause the loss of limb or life." She confirmed this is an important medication to receive.

On 10/14/21 at 2:10 PM, a telephone interview was conducted with Employee F, the Nurse Practitioner. Employee F was asked about the medication Brilinta and its use. Employee F stated, "it is an anticoagulant usually given when people have heart failure, it is a last ditch effort". When asked the risks if someone doesn't get this as ordered, Employee F stated, "it depends on the circumstances, 1 dose is not terrible but missing multiple doses could put them at risk for heart failure or create clots". Employee F was made aware that Resident #24 had missed 3 of 4 scheduled doses in a 48 hour period. Employee F stated she was not aware of this.

On 10/15/21 at 11:30 AM, a telephone interview was conducted with Other Staff B, the pharmacist. Other Staff B stated, "Brilinta is an antiplatelet medication, the reason someone takes it is to prevent a thromboembolism (blood clot) or MI (myocardial infarction/heart attack). Missed doses would result in higher risks for these things". Other Staff B stated, the pharmacy makes 2 deliveries to the facility daily and also has a local retail pharmacy that can be used for

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back-up if medications are not available and are not in the Omnicell [emergency box of medications maintained on-site]. When asked about cut off times, she stated, "if a medication is ordered before 11:30 PM, we have it on the delivery that comes that night, same for the day delivery, as long as we get it [the order/refill request] about an hour to 30 minutes before we leave the pharmacy with the delivery, it can be included in that delivery".

The facility policy titled "Medication Related Errors" read, "4. Administration Errors: In the event of an administration error, facility staff should follow facility policy relating to the medication administration errors.....4.9 Omission Error: Facility fails to administer an ordered dose to the resident, unless refused by the resident or not administered because of recognized contraindication".

On 10/14/21, the facility Administrator and DON were made aware of the findings.

No further information was received.

3. For Resident #178 the facility staff failed to administer insulin, antibiotics, pain medications, medications as ordered by physician.

A review of the clinical record revealed that Resident #178 was admitted to the facility on 8/12/21 at 8 PM, after having been hospitalized and had surgery for necrotizing fasciitis (also known as flesh eating bacteria) to her inner thigh.

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Among Resident # 178's discharge summary were orders for the following medications:

Resident #178 had an order for Clindamycin 300 mg one capsule every six hours (an antibiotic). -A review of the MAR (Medication Administration Record) revealed that Resident #178 did not receive 5 doses of this medication - A review of the progress notes revealed that nurses documented medication was unavailable. However, a review of the stat box contents revealed this medication was available in the stat box.

Resident #178 had an order for Cefepime 2 grams/100 ml IV (an antibiotic) A review of the MAR revealed that the resident did not receive seven doses of IV Cefepime 2 grams/ 100 ml between 8/12/21 and 8/15/21.

Progress note on 8/14/21 at 11:50 AM read: "Pharmacy contacted re: Cefepime HCl solution reconstituted 2 grams as medication not received. Per pharmacy IV department not available at this time message left for a return call."

"8/14/21 at 4:11 PM IV department contacted no return call received per pharmacy IV department IV antibiotics order not received order re-faxed to the pharmacy order currently not updated in [name of pharmacy computer program redacted] to pull medication for administration."

"8/15/21 at 3:59 PM Pharmacy contacted again this shift as IV abx not received. Per pharmacy medication not sent d/t allergy to Ceclor. Per discharge information, resident was receiving this medication in hospital without side effects.

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On-call NP made aware with approval to contact pharmacy again and update on approval to send medication. Pharmacy verbally contacted + faxed for notification of approval to continue IV abx per current orders."

Resident #178 had an order for Gabapentin 600 mg 1 tablet three times a day for neuropathic pain-A review of the MAR revealed the resident missed nine doses of gabapentin. A review of the progress notes revealed the nurses documented medication unavailable awaiting from pharmacy. A review of the Stat Box contents revealed the medication was available in the stat box in a lower dose strength (300 mg)

Resident #178 had an order for Insulin Glargine (Lantus) 60 units a day missed 6 doses. The facility MAR has orders that read:
"Insulin Glargine (Lantus) solution 100 units/ml inject 60 units subcutaneously at bedtime for DM2 (diabetes) Start Date 8/12/21 at 9:00 PM"
A review of the MAR reveals that it is coded as 19 (which means see nurses notes) for 8/12/21 - 8/16/21 (4 missed doses) then it was discontinued on the 16th and not restarted until 8/18/21. (2 more doses missed). A review of the Nurses notes revealed the nurses were documenting "waiting for med from pharmacy."

On 10/13/21 at approximately 11:25 AM an interview was conducted with the DON who was stated the Pharmacy makes two runs a day. They come in the middle of the night and in the middle of the day. When asked how long it takes to get orders in the system for a new admission she stated that it takes about 2 hours. When asked what the cutoff time to get the medications on the next run she stated it is at 11:30 PM. She

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further stated that Resident #178 should have had her medications in the middle of the night run. When asked if there is a backup pharmacy she stated that there was a backup pharmacy.

On 10/14/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

4. For Resident #62, the facility staff failed to administer Lantus (Insulin Glargine) on 10/04/2021 and 10/05/2021 as ordered by the physician. Also, Novolog (Insulin Aspart) was not signed off as administered on 10/06/2021 at 0800 (8:00 A.M.) and 1700 (5:00 P.M.)

On 10/25/2021 at approximately 9:45 A.M., Resident #62's clinical record was reviewed. A physician's order dated 08/02/2021 documented, "Lantus Solution 100 unit/ml [milliliters] (Insulin Glargine) Inject 65 unit subcutaneously at bedtime for DMII [diabetes mellitus type 2]. A physician's order dated 08/05/2021 documented, "Novolog (Insulin Aspart) 100 unit/ml [milliliters] Inject per sliding scale ..." A physician's order dated 08/20/2021 documented "Novolog (Insulin Aspart) 100 unit/ml. Inject
5 unit subcutaneously with meals for DMII in addition to sliding scale."

The Medication Administration Record (MAR) for October 2021 was reviewed.

Pertaining to Lantus (Insulin Glargine) Inject 65 units subcutaneously at bedtime:
The Lantus was signed off as administered at bedtime with the exception of 10/04/2021 and 10/05/2021. For 10/04/2021 and 10/05/2021, the

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administration Insulin Glargine (65 units) at 2100 [9:00 P.M.] was coded as "3" meaning "no insulin required" (according to the MAR legend). The "BS [blood sugar]" value on 10/04/2021 at 2100 was documented as "183". The "BS [blood sugar]" value on 10/05/2021 at 2100 was documented as "125".

Pertaining to Novolog (Insulin Aspart) Inject 5 unit subcutaneously with meals for DMII in addition to sliding scale:
The Novolog was signed off as administered with the exception of 10/06/2021 at 0800 [8:00 A.M.] which was coded as "19" meaning "other/see nurses notes" (according to the MAR legend) and 10/06/2021 at 1700 [5:00 P.M.] which was blank.

A nurse's note dated 10/06/2021 at 11:23 A.M. documented that the Novolog was "on order." There was no nurse's note addressing why Novolog was not signed off as administered on 10/06/2021 at 1700.

On 10/25/2021 at 11:50 A.M., an interview with Licensed Practical Nurse D (LPN D) was conducted. When asked about the process if insulin is unavailable for administration, LPN D stated they have an emergency supply of insulin in the refrigerator. LPN D stated they would use the emergency supply and also notify the pharmacy. This surveyor and LPN D then went to observe the "ekit" contents for insulin which did contain several types of insulin vials and pens including Lantus and Novolog.

On 10/25/2021 at 1:00 P.M., the Director of Nursing (DON) was notified of findings and the DON indicated she would look into it. At 2:20 P.M., the DON stated that it was an agency nurse

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F 760	Continued From page 40 that documented "no insulin required" for the Lantus on 10/04/2021 and 10/05/2021. The DON also stated that "I can't speak for her" but it looked like she was addressing the sliding scale [where no insulin was required for blood sugar values less than 200] and applied it to the Lantus. Pertaining to the nurse's note indicating Novolog was "on order" and not administered, the DON stated that staff are expected to use the extra insulin supply on hand and doesn't know why it wasn't administered. On 10/25/2021 at approximately 3:30 P.M., the administrator was notified of findings. The administrator and DON stated there was no further information or documentation to submit.	F 760		
F 770 SS=G	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review and in the course of a complaint investigation, the facility staff failed to ensure Laboratory services were provided to meet the needs of one resident (Resident # 128) in a survey sample of 41 residents resulting in harm.	F 770	F770 Resident #128 was discharged prior to the survey. All residents are at risk. The ADON audited current Resident charts on 10/19/2021 to ensure that all labs ordered for completion since 8/28/2021 were	11/22/21

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F 770	Continued From page 41 The Findings Included: 1. For Resident # 128, the facility staff failed to obtain a Complete Blood Count, Basic Metabolic Profile as ordered to be drawn on 8/28/2021. The labs were not drawn prior to Resident # 128 being hospitalized on 9/17/2021 for hypotension (low blood pressure), increased confusion and dysphagia (difficulty swallowing). When the labs were checked in the Emergency Room, there were several values at Critical levels. This is harm. The finding included: Resident # 128 was admitted to the facility on 8/23/2021 Resident # 128's diagnoses included but were not limited to Left foot gangrene and osteomyelitis, status post left foot trans metatarsal amputation. Review of the Clinical record was conducted on 10/12/2021-10/15/2021. Review of the Nurse Practitioner's Progress Notes revealed documentation of an order for labs -Complete Blood Count, Basic Metabolic Profile to be drawn on 8/28/2021. Review of the Nursing Progress Notes revealed a note written by LPN (Licensed Practical Nurse) B which read: "8/28/2021 12:17 eMAR- Medication Administration Note Text: check CBC, BMP, Mg (Complete Blood Count, Basic Metabolic Profile and Magnesium) one time only for 1 Day Lab to be obtained 7 p-7 a shift by ____ (Name of lab services)."	F 770	obtained as required and her findings reviewed with the Nurse Practitioner/MD for corrective action. Licensed nurses to be educated by the DON/designee on the process for obtaining lab services. New hires and agency staff will receive these trainings during their orientation. Nursing Administration will monitor physician orders daily during their clinical meeting and ensure that labs are drawn and results obtained and reported to the ordering provider in a timely manner. The DON/designee will track/trend findings from these reviews and report monthly at QAPI x 3 months for additional input and to ensure compliance with this plan of correction.	

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Further review of the clinical record revealed no documentation of the nursing staff notifying the Nurse Practitioner or Medical Director that the labs were not drawn on 8/28/2021 as ordered.

There was no documentation of the laboratory service drawing blood on Resident # 128 on 8/28/2021 or on any other day during the stay at the facility.

Further review of the Nursing Progress Notes and the rest of the clinical record revealed no documentation of the bloodwork being drawn as ordered.

Review of the Nurses Notes dated 9/17/2021 revealed documentation of Resident # 128 being transferred to the hospital for altered mental status.

Review of the hospital records dated 9/17/2021 revealed Resident # 128 had bloodwork drawn while in the Emergency Room. Review of the laboratory values revealed several abnormal lab values including many critical values. Among those labs listed as critical lab values were the Hemoglobin and Hematocrit and Magnesium levels. The Hemoglobin was 4.7 (normal value range-12.0-18.0) and the Hematocrit was 15.1 (normal range-37.0 - 47.0).

Resident # 128 was admitted to the hospital from the Emergency Room.

On 10/14/2021, during the end of day debriefing at approximately 4:35 PM, copies of all lab results for Resident # 128 were requested. The Administrator stated she had lab results from when Resident # 128 was sent to the hospital and

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would submit them on 10/15/2021.

Review of the laboratory results presented by the Administrator revealed the blood work-a Magnesium level with a Critical Level result = 3.1. The normal range for Magnesium Levels is (1.5-2.4). The Administrator stated that was the only lab value she could find. The Administrator was advised of other Critical Lab values when Resident # 128 was evaluated in the Emergency Room. Resident # 128 was transferred to the Emergency Room due to being symptomatic.

On 10/15/2021 at 11:05 A.M., an interview was conducted with Licensed Practical Nurse B who stated she reviewed Resident # 128's clinical record and "it does not appear that the lab was done." When asked if the laboratory usually would draw labs, LPN B stated the labs were would be drawn on the night shift. LPN B stated the nursing staff was expected to notify the physician if the labs were not drawn. LPN B stated there was no documentation that the doctor was notified of the labs not being drawn as ordered.

On 10/15/2021 at 11:35 A.M., an interview was conducted with the Director of Nursing who stated the labs were not drawn. The Director of Nursing stated "it looks like the nurse put it on the weekend to be drawn." When informed that the physician scheduled the lab to be drawn specifically on 8/28/2021 which was a Saturday, the Director of Nursing stated she did not realize 8/28/2021 was a Saturday. She stated she had not looked at the calendar prior to talking to the surveyor.

The Director of Nursing again stated the labs had

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not been drawn as ordered by the provider. The Director of Nursing stated the "facility has lab services every day because the nurses here can draw labs. But if the lab service is coming, the nurses will get the lab to do it."

On 10/15/2021 at 12:04 P.M., the Medical Director returned the call from the surveyor. The Medical Director stated she reviewed the clinical record and that there were no labs drawn on Resident # 128. She stated the expectation was that the lab would have been drawn as ordered on 8/28/2021. The Medical Director stated "They got missed for some reason from the lab personnel not coming. They are also short staffed. Sometimes if they do not draw it (labs) on the Saturday, then it should be drawn that Monday and the staff should have informed me." Then she stated "at least it would have been drawn on the next possible day."

The Medical Director stated she saw a hemoglobin of 8 in the clinical record. When the surveyor informed the Medical Director that the lab value of Hemoglobin result of 8 was prior to admission to the facility, the Medical Director stated she would review the clinical record again.

The Medical Director was informed that the clinical record indicated that Resident # 128 was sent to the Emergency Room by the Nurse Practitioner for "hypotension, increased confusion, and dysphagia, as the resident's needs can no longer be met in the facility." The Medical Director stated she was unaware that several lab values were critical when Resident # 128 was evaluated in the Emergency Room on 9/17/2021. When this surveyor informed the Medical Director of the critical Hemoglobin value

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of 4, and Hematocrit of 15, the Medical Director stated those values were very critical.

The Medical Director also stated that Resident # 128 was "not clinically bleeding, the blood pressure was stable and did not suggest that it was not indicative of a hemoglobin that low. The Medical Director said "Oh okay" when informed that Resident # 128 was symptomatic and that was why the transfer to the Emergency Room order was written by the nurse practitioner.

The Medical Director was informed that Resident # 128 had an altered mental status and the hospital record revealed vitals signs on 9/17/21 with a Blood pressure-83/52 and heart rate-94. The Medical Director stated it was important to draw labs as ordered.

On 10/15/2021 at 12:58 P.M., the Director of Nursing was interviewed after reviewing the medical record. The Director of Nursing stated she found documentation of a Nursing note with a code that indicated the physician and responsible party had been notified about something on 8/28/2021. The Director of Nursing stated she could not determine what information they had been notified of since it was not documented clearly in the note. The Director of Nursing was asked for the name of the On call doctor. The Director of Nursing stated she would submit the name and contact number.

The Director of Nursing stated the note should have described what was discussed when the on call doctor and family were notified.

Review of the Nurses Note described by the Director of Nursing revealed documentation on

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F 770	Continued From page 46 8/28/2021 at 3:02 P.M. that read: "Nursing Note-Note Text: On-call MD made aware +emergency contact made aware." According to the documentation by the same nurse (LPN B) who documented about notifying the On Call Physician and Emergency Contact, the labs were not scheduled to be drawn until the 7 p-7 a shift on 8/28/2021. In Summary, the nursing staff failed to draw the blood for labwork as ordered by the provider on 8/28/2021. The resident had a low hemoglobin and Hematocrit upon initial admission to the facility on 8/23/2021 as well as a history that included Gastrointestinal Bleeding. The nurse practitioner ordered labwork to be drawn on 8/28/2021. The labs were never drawn, the resident became symptomatic and had critical lab values when evaluated in the ER on 9/17/2021. Resident # 128 was scheduled to be discharged to home on 9/18/2021 but was admitted to the hospital the day before due the changes in condition. During the end of day debriefing on 10/15/2021, the Facility Administrator, Director of Nursing and Regional Consultant were informed of the findings. No further information was provided.	F 770		
F 790 SS=D	COMPLAINT DEFICIENCY Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining	F 790		11/22/21

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F 790	Continued From page 47 routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on interview, observation, clinical record	F 790	F790	

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 790	Continued From page 48 review and facility documentation the facility staff has failed to ensure routine and emergency dental care for 1 Residents (# 16) in a survey sample of 41 Residents. The findings included: For Resident #16 the facility staff failed to ensure Residents received routine and emergency dental care. On 10/13/21 a review of the clinical record revealed that Resident #16 had order that read: "Warm compress to affected area (toothache/pain) as needed every four hours as needed for toothache/pain times 20 minutes start date 9/23/2020 at 1 PM." This order was still active, over a year later, and was signed off as administered as recently as 10/11/2021 at 10:26 AM. Resident #16 had another orders that read: "X-ray left jaw/mandible for edema one time a day for one day start date 10/14/21 at 12:30 PM." "Pending confirmation clindamycin HCl capsule 300 mg two capsules by mouth four times a day for left side dental infection start date 10/14/21." "Pending confirmation please make a follow up appointment with dental for left side tooth infection one time only for four days start date 10/15/21: 9 AM." On 10/13/21 at approximately 9:15 AM an attempt was made to interview Resident #16 who stated she did not want to answer any questions.	F 790	Resident #16 discharged from the facility on 10/17/2021. All residents are at risk. On 10/18/2021, the unit manager conducted a visual inspection of residents oral cavity and documented her findings along with the residents desire or refusal of dental services. Appointments were made on 10/18/2021 through 10/21/2021 for all residents requesting dental services and the physicians notified of any pain control or other oral care needs required in the interim. The SW and Office Manager met with the contracted dental service on 10/25/2021 and added additional eligible residents to the dental insurance program. Nursing staff to be educated by DON/designee on monitoring and reporting dental concerns and the process for obtaining dental services via notification to the Unit Mangers. Department Managers will be educated by the Administrator as to the need to query residents on concierge rounds regarding any dental pain or concerns that they have and to report these concerns to Nursing Administration immediately as well as to document the findings on their concierge rounds sheets for daily review in morning meeting. New hires and agency staff will receive these trainings during their orientation. Concierge Round sheets will be submitted weekly to the Administrator auditing dental needs to the residents chart to ensure that	

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F 790	Continued From page 49 On 10/13/21 at 10:00 AM an interview was conducted with RN C who was asked if Resident #16 had any dental issues she was aware of, she stated that there has been an order in the chart for warm compress for a while and she knows that she has recently complained of tooth pain. When asked how the Residents get appointments to see the dentist she stated that the Social Worker handles the dental and vision appointments. On 10/13/21 at approximately 11:00 AM an interview was conducted with the Social Worker who stated that she was the person who made the appointments for dental work. She stated that right now she had "about 5 people that needed to be seen by a dentist." When asked if the Residents receive routine dental checkups she explained that some people could pay a fee (as insurance does not cover the visiting dentist) and have the dentist come to the facility and see the Resident. For Residents that could not afford that option she would arrange to have them seen outside the facility, however she was having trouble finding dentists that accept Medicaid in the area. She stated she thought Resident #16 was not a candidate for the in facility dentist. She stated that someone had suggested the local dental school in Richmond but she had not looked into that as of yet. She stated that she had called the local health department and has not received a call back. She stated that she had made a lot of phone calls and she will continue to try and find a dentist for them. On 10/14/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 790	dental appointments were made and attended with findings of these audits reported monthly x 3 months to QAPI for monitoring of compliance with this plan of correction.	

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F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility documentation review, the facility staff failed to store and serve food in accordance with professional standards. Specifically, the gas range top was unclean and contained pasta and rice from previous days according to the menu; there were prepared food items in the walk-in refrigerator which were not dated; and there was milk on the tray line which had a temperature of 54.3 degrees Fahrenheit. The findings included: On 10/12/2021 at approximately 11:15 A.M., this surveyor and the dietary manager made the following observations in the walk-in refrigerator:	F 812	F812 The unlabeled and outdated items were disposed of and the stove was cleaned during the survey. All Residents on a PO diet are at risk from this deficiency. The dietary manager educated all dietary staff on the requirements related to food procurement/preparation and requirements for storage and sanitation on 10/13/2021. New hires and in the dietary department will receive these trainings during their orientation. The dietary manager will conduct daily	11/22/21

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F 812	Continued From page 51 1) Three square slices of what appeared to be cake were covered with plastic wrap, unlabeled and undated. The dietary manager stated the cake should be labeled and dated and removed them from the refrigerator. 2) Four cups of pudding (labeled "P") were undated. The dietary manager stated the pudding should be dated and removed them from the refrigerator. 3) Ten package of tortilla wraps (approximately 15 tortillas per wrap) had hand written dates of "06/22." There was no year and there was no manufacture's date on the packaging. The dietary manager stated the year and manufacturer's date were unknown and removed the tortilla packages from the refrigerator. On 10/12/2021 at approximately 11:30 A.M., this surveyor and the dietary manager observed several uncooked spaghetti pieces on the gas range top including in the left front burner ring. There were also several white rice kernels observed including some burned kernels stuck to the gas range top. The dietary manager provided a copy of the menu for October 2021. Per the menu, the dietary manager confirmed spaghetti was last served on 10/09/2021 (3 days prior to the observation) and rice the previous day (10/11/2021). When asked about expectations for cleaning the cooktop, the dietary manager stated it should be cleaned daily. On 10/12/2021 at 12:55 P.M., the administrator was notified of findings. On 10/13/2021 at approximately 4:55 P.M., this surveyor observed the dietary manager check the temperature of the milk that was on the tray line	F 812	inspections of the kitchen 5 times per week utilizing the Food and Nutrition Services Sanitation Audit with immediate corrective action taken as needed. The audit sheets will be turned into the Administrator weekly for review and tracking/trending to QAPI monthly x 3 months for additional input and to ensure compliance with this plan of corrections.	

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F 812	Continued From page 52	F 812		

to be served. The two milk cartons were on the table and not in the ice bind. The temperatures of the milk in each of the containers were 54.3 degrees Fahrenheit and 53 degrees Fahrenheit. The dietary manager stated the milk was too warm and could not be served at that temperature and removed them. The dietary manager stated she would also educate the staff to keep the milk in the ice bin on the tray line prior to serving. This surveyor and the dietary manager then observed the food temperature log for this tray line. The temperature for milk was not measured. Dietary staff member, Employee M, verified it was her job to record the food temperatures. When asked why the temperatures for the milk were not checked, Employee M stated she did not know milk was on the tray line.

On 10/12/2021, the facility staff provided a copy of their policy entitled, "Food Temperature Policy." In Section 2 under the sub-header entitled, "Cold Foods" it was documented, "The temperature of potentially hazardous cold foods must be served at a temperature of 41 degrees Fahrenheit or below."

On 10/12/2021, the facility staff provided a copy of their policy entitled, "Storage of Refrigerated Foods." An excerpt in Section 14 documented, "Refrigerated items must have a label showing the name of the food and the date it should be consumed, or discarded." The facility staff also provided a copy of a spreadsheet of food storage expectations. The document indicated that refrigerated pudding was good for 2 days and refrigerated cake was good for 7 days.

On 10/14/2021, the administrator was notified of findings and stated they had no further

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F 812	Continued From page 53 information or documentation to submit.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation	F 842		11/22/21

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F 842	Continued From page 54 purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain an accurate clinical record for one Resident (Resident #65) in a sample size of 41 Residents. For Resident #65, there was conflicting information regarding blood glucose values on 10/06/2021.	F 842	F842 Resident #65's medical records was audited by the DON/designee for accuracy of blood sugar documentation. All residents receiving blood glucose checks are at risk. All residents receiving blood glucose monitoring are at risk.	

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F 842	Continued From page 55 The findings included: On 10/25/2021 at approximately 10:00 A.M., Resident #65's clinical record was reviewed. A physician's order dated 09/11/2020 documented, "Obtain blood sugars ac & hs [before meals and at bedtime]." The Medication Administration Record for October 2021 was reviewed. The blood sugar values for 10/06/2021 documented the following: 0630 [blank] 1130 "245" 1630 "232" 2030 "301" On 10/25/2021 at 1:00 P.M., the Director of Nursing (DON) was notified of findings. At 3:00 P.M., this surveyor and the DON observed Resident #65's glucometer. The Director of Nursing stated that there are dates but no times listed in the blood sugar history. The blood sugar values listed in the glucometer for 10/06/2021 were 245, 232, 305, and 324. The DON also provided a clinical record document for Resident #65 entitled, "Weights and Vitals Summary." Under the sub-header "Blood Sugar" for 10/06/2021, it was documented, "12:01, 245 mg/dL [milligrams per deciliter]." "17:19 [5:19 P.M.], 232 mg/dL." The DON acknowledged the conflicting information and indicated this was an inaccurate clinical record. In summary, there was conflicting/incomplete information regarding Resident #65's blood sugar values on 10/06/2021 between the Medication Administration Record, the Vitals Summary document, and the glucometer.	F 842	Blood glucose monitoring documentation for prior 2 weeks (10/11/21-10/25/21) to be reviewed by the DON/designee and education for any negative findings will be reviewed with nurse responsible. Licensed nurses will receive education by the DON/designee as to the requirement to have complete and accurate medical records to include the accurate completion and documentation of all ordered glucose monitoring. New hires and agency staff will receive these trainings during their orientation. Nursing administration will monitor reports from the electronic medical record daily (Monday through Friday) during their morning clinical meeting with immediate corrective action taken as required for any identified discrepancies in documentation of blood glucose monitoring. The DON/designee will track/trend findings from these daily reviews and report at QAPI monthly x 3 months for additional input and to ensure compliance with this plan of correction.	

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F 842	Continued From page 56 On 10/25/2021 at approximately 3:30 P.M., the administrator was notified of findings and indicated there was no further documentation or information to submit.	F 842		