STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495388	A. BUILDING _____ B. WING _____	C 09/16/2021

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GAINESVILLE HEALTH AND REHAB CENTER	7501 HERITAGE VILLAGE PLAZA GAINESVILLE, VA 20155

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted on 9/16/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard and Focused Infection Control survey was conducted 9/14/21 through 9/16/21. Three complaints were investigated during the survey (VA00052294 - substantiated; VA00052291 - unsubstantiated; VA00052075 - substantiated). Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care - Requirements. The Life Safety Code survey/report will follow. The census in this 120 bed facility was 89 at the time of the survey. The survey sample consisted of 24 current resident reviews and seven closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodations of resident needs by ensuring	F 558	1. It is noted facility staff failed to provide accommodations of residents needs by ensuring the call bell was within reach for resident #70. #70 call bell placed in reach.	10/26/21

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

Electronically Signed | 10/07/2021

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F 558	Continued From page 1 the call bell [a device with a button that can be pushed to alert staff when assistance is needed] was within reach for one of 31 current residents in the survey sample, Resident # 70. The facility staff failed to maintain Resident # 70's call bell within reach for use. The findings include: Resident # 70 was admitted to the facility with diagnoses that included but were not limited to: hemiplegia [1] and muscle weakness, respiratory failure [2] and tracheostomy [3]. Resident #70's most recent MDS (minimum data set) assessment, a modification admission assessment with an ARD (assessment reference date) of 08/09/2021, coded Resident # 70 as scoring a 6 [six] on the brief interview for mental status (BIMS) of a score of 0 - 15, 6 - being severely impaired of cognition for making daily decisions.. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 70 as "Impairment on one side" of their upper extremities [shoulder, elbow, wrist, hand] and lower extremities [hip, knee ankle, foot]. On 09/14/21 at 3:58 p.m., during an interview with Resident # 70, was asked if she was able to locate the call bell. Resident # 70 stated, "No. I haven't had it since this morning." Observation of Resident # 70's room revealed the call bell hanging over and down the headboard of the resident's bed, out of Resident # 70's reach. On 09/14/21 at 5:00 p.m., an observation of Resident # 70's room revealed the call bell hanging over and down the head board of the	F 558	2. Any resident who resides at the center could be affected if their call bell is not within reach. 100% audit of resident call bells will be done to ensure call bell is in reach. 3. The Don or designee will educate center staff on call bell accessibility. 4. DON or designee will audit call bell accessibility 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 5. Date of compliance is 10/26/21.	

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F 558	Continued From page 2	F 558		

resident's bed, out of Resident # 70's reach.

The comprehensive care plan for Resident # 70 dated 08/03/2021 documented in part, "Focus: [Resident # 70] is at risk for falls. Date Initiated: 08/03/2021." Under "Interventions" it documented in part, "Orient patient and family to room, call bell, lighting, and bathroom. Encourage to use call for assistance with needs. Date Initiated: 08/03/2021."

On 09/16/2021 at 9:26 a.m., an interview was conducted with CNA [certified nursing assistant] # 6. When asked about the position of a call bell for a resident, CNA # 6 stated, "So they can reach it." When asked how often the position of call bell is checked, CNA # 6 stated, "You check it every time you go in [the resident's room]." When asked why it was important to maintain the call bell within a resident's reach, CNA # 6 stated, "It's a way for the resident to ask/call for help or assistance."

On 09/16/2021 at approximately 3:35 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, director of operations and ASM # 4, clinical service specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or

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F 558	Continued From page 3 both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html.	F 558		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the	F 582		10/26/21

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F 582	Continued From page 4 facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined the facility staff failed to issue a notice of discharge from Medicare services for three of 31 residents in the survey sample, Residents # 91, #145, #146. The findings include: 1. Resident #91's last covered Medicare Part A services was 8/8/2021. The facility staff failed to notify Resident #91 (and/or the resident's responsible representative) of the last covered day and the right to appeal. Resident #91 was admitted to the facility on 7/24/2021 with diagnoses that included but were not limited to: high blood pressure, COVID 19	F 582	1. It is noted that facility staff failed to issue a notice of discharge from Medicare services for resident # 91, 145, and 146. Residents #91, #145 and #146 no longer reside in center. 2. Any resident who resides at the center could be affected if a notice of discharge from Medicare services is not issued. A 30day review of all discharges notice will be reviewed for completion any variances will be corrected. 3. The Don or designee will educate Social Services will be educated on issuing notices of discharge from Medicare services timely and accurately. 4. Administrator or designee to audit notices of discharge of Medicare services twice weekly for 12 weeks and report	

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F 582	Continued From page 5	F 582		

pneumonia (an infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia) (1), and dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation. (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/8/2021, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions.

The Beneficiary Notice - Residents Discharged Within the Last Six Months form given to the administrator upon entrance was reviewed on 9/15/2021. It was documented on this form that Resident #91 was discharged from Medicare services on 8/8/2021. Review of the clinical record failed to evidence the documentation of the discharge from Medicare services.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 9/16/2021 at 12:16 p.m. ASM #1 stated she did not have a notice to the resident or resident's representative about the last covered Medicare day and the right to appeal. ASM #1 stated there was a new social worker and she did not know she had to do these.

The policy provided to the survey team, entitled, "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN)." documented in part, "Medicare requires SNFs (skilled nursing facility) to issue the SNFABN to Original Medicare, also called

findings to QAPI committee.
5. Date of compliance is 10/26/21.

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fee-for -service (FFS) beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial. The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume the financial responsibility, SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A). SNFs will continue to use the ABN Form CMS (centers for Medicare/Medicaid services) when applicable for Medicare Part B items and services."

ASM #1, ASM #2, the director of nursing, ASM # 4, the clinical services specialist and ASM #3, the director of operations, were made aware of the above concern on 9/16/2021 at 3:33 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website: https://medlineplus.gov/pneumonia.html.
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

2. Resident #145's last covered Medicare Part A services was 8/8/2021. The facility staff failed to notify Resident #145(and/or the resident's responsible representative) of the last covered day and the right to appeal.

Resident #145 was admitted to the facility on 6/22/2021 with diagnoses that included but were not limited to: diabetes and high blood pressure.

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F 582	Continued From page 7	F 582		

The most recent MDS (minimum data set) assessment, a discharge assessment, with an assessment reference date of 7/13/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

The Beneficiary Notice - Residents Discharged Within the Last Six Months form given to the administrator upon entrance was reviewed on 9/15/2021. It was documented on the form that Resident #145 was discharged from Medicare services on 8/8/2021. Review of the clinical record failed to evidence the documentation of the discharge from Medicare services.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 9/16/2021 at 12:16 p.m. ASM #1 stated she did not have a notice to the resident or resident's representative about the last covered Medicare day and the right to appeal. ASM #1 stated there was a new social worker and she did not know she had to do these.

ASM #1, ASM #2, the director of nursing, ASM # 4, the clinical services specialist and ASM #3, the director of operations, were made aware of the above concern on 9/16/2021 at 3:33 p.m.

No further information was provided prior to exit.

3. Resident #146's last covered Medicare Part A services was 6/10/2021. The facility staff failed to notify Resident #146 (and/or the resident's responsible representative) of the last covered day and the right to appeal.

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Resident # 146 was admitted to the facility on 3/7/2021 with diagnoses that included but were not limited to: anxiety disorder (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat.) (1), depression and COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/1/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions.

The Beneficiary Notice - Residents Discharged Within the Last Six Months form given to the administrator upon entrance was reviewed on 9/15/2021. It was documented on the form that Resident #146 was discharged from Medicare services on 6/10/2021. Review of the clinical record failed to evidence the documentation of the discharge from Medicare services.

An interview was conducted with ASM (administrative staff member) #1, the administrator, on 9/16/2021 at 12:16 p.m. ASM #1 stated she did not have a notice to the resident or resident's representative about the last covered Medicare day and the right to appeal. ASM #1 stated there was a new social worker and she did not know she had to do these.

ASM #1, ASM #2, the director of nursing, ASM #

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F 582	Continued From page 9 4, the clinical services specialist and ASM #3, the director of operations, were made aware of the above concern on 9/16/2021 at 3:33 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 43. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 582		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		10/26/21

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F 609	Continued From page 10 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a witnessed allegation of abuse was reported immediately and or within 2 hours to the state agency for one of 31 residents in the survey sample, Resident #297. On 5/8/21, a staff member observed Resident #64 repeatedly slamming his wheelchair into Resident #297's wheelchair. The facility did not report this incident to the state agency. The findings include: Resident #297 no longer resides in the facility. She was admitted on 4/19/21 and discharged on 5/15/21. She was admitted with diagnoses including urinary tract infection, COPD (3), and anxiety disorder. On the most recent MDS, an admission assessment with an ARD of 4/26/21, she was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS. She was coded as being completely dependent on facility staff for all ADLs, and as using a wheelchair for locomotion. Resident #64 was admitted to the facility on 7/25/18 with diagnoses including a femur fracture, bipolar disorder (1), epilepsy (2), alcohol abuse, and nicotine dependence. On the most recent MDS (minimum data set), an annual assessment	F 609	1. It is noted that facility staff failed to report a witnessed allegation of abuse for resident # 297. Resident #297 no longer resided in the center. 2. Any resident who resides at the center could be affected if allegations of abuse are not reported. 3. The Don or designee will educated Center Staff will be educated on facility reported incidents and allegations of abuse. 4. Administrator or designee will audit charts to ensure all allegations of abuse are reported timely and accurately weekly. 5. Date of compliance is 10/26/21.	

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with an ARD (assessment reference date) of 8/3/21, Resident #64 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having demonstrated no mood disorder symptoms, no psychosis, no behaviors toward himself or others, no rejection of care, and no wandering. He was coded as being independent in all ADLs (activities of daily living), as having no functional limitations with range of motion in upper or lower extremities, and as always continent of both bladder and bowel. He was coded as using a wheelchair for locomotion during the look back period.

Review of Resident #64's clinical record revealed an entry dated 5/8/2021 16:14 (4:14 p.m.), that documented in part the following: "*Behavior Note Behavior Observed (Onset and Duration): Cna (certified nursing assistant) reported to writer that she observed resident slamming his wheelchair into the same resident [Resident #297] wheelchair multiple times. Cna also stated resident had enough room to pass around the resident without slamming the wheelchair."

A review of Resident #64's comprehensive care plan dated 7/25/18 and most recently updated 8/16/21 revealed, in part: "Resident #64 is at risk of a change/decline in his mood and/or psychosocial status d/t (due to) continuing ETOH abuse, nicotine dependence, hx of aggressive/intimidating behavior toward elderly residents, being younger than the general population... Encourage and allow to ventilate feelings..., Mental Health Consult ....."

Further review of Resident #64's clinical record

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revealed in part the following documented after the above incident on 5/8/21: "5/14/2021 11:30 (11:30 a.m.) Social Services Note Late Entry: Note Text: IDT (interdisciplinary team) conducted Care Plan Meeting with Resident to discuss behavior management. IDT Members present for meeting include: Administrator, DON (director of nursing), ADON (assistant director of nursing), SS (social services) Care Coordinator, Psych (psychiatry) NP (nurse practitioner), and Psychologist. Resident denied being verbally or physically aggressive toward staff or other residents on 05/08/2021."

On 9/15/21 at 1:58 p.m., ASM (administrative staff member) #1, the administrator, and ASM #4, the clinical services specialist, were interviewed. When asked if the facility had submitted a FRI (facility reported incident) regarding the 5/8/21 altercation between Resident #64 and Resident #297, ASM #1 stated there were no FRIs related to that incident. ASM #1 stated: "It was a resident-to-resident incident. A FRI should have been submitted."

On 9/16/21 at 9:51 a.m., ASM #1, ASM # 3, director of operations and ASM # 4, clinical service specialist, were informed of these concerns.

On 9/16/21 at 11:41 a.m., ASM #2, the DON (director of nursing) was interviewed. When asked what should happen when a resident to resident altercation occurs, he stated it should be reported to the state agency.

A review of the facility policy, "Abuse Prevention," revealed, in part: "The facility administrator, DON, or designee must report all alleged incidents of

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abuse, neglect, exploitation...and unusual occurrences using the [name of State Agency] "Facility Reported Incident" form to the...State Agency and to all required agencies."

No further information was provided prior to exit.

REFERNCES

(1) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) "The epilepsies are a spectrum of brain disorders ranging from severe, life-threatening and disabling, to ones that are much more benign. In epilepsy, the normal pattern of neuronal activity becomes disturbed, causing strange sensations, emotions, and behavior or sometimes convulsions, muscle spasms, and loss of consciousness." This information is taken from the website https://www.ninds.nih.gov/Disorders/All-Disorders/Epilepsy-Information-Page.

(3) "COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. COPD can cause coughing that produces large amounts of a slimy substance called mucus, wheezing, shortness of breath, chest tightness, and other symptoms." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/copd.

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		10/26/21

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F 623	Continued From page 15 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 16 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure written notification of a hospital transfer was provided to the Ombudsman for one of 31 residents in the survey sample, Resident #58. The facility staff failed to provide notice to the ombudsman of Resident #58's transfer to the hospital on 8/22/21. The findings include: Resident #58 was admitted to the facility on 7/9/21 with the diagnoses of but not limited to myoclonus, epilepsy, nonpsychotic mental disorder, substance abuse, anxiety, and depression. The most recent MDS (Minimum Data Set) assessment, a quarterly assessment with an ARD (Assessment Reference Date) of 8/5/21 coded Resident #58 as cognitively intact to	F 623	1. It is noted that facility staff failed to ensure written notification of a hospital transfer was provided to the ombudsman for resident #58. Resident #58 written notification given to ombudsman on 9-30-21 2. Any resident who resides at the center could be affected if written notification of hospital transfer is not provided to the ombudsman. A 30 day review all residents that have transfer to the hospital will be reviewed to ensure written notification was given to the ombudsman any variances will be corrected. 3. The Don or designee will educate social workers on providing the ombudsman with written notification of transfer. 4. Administrator or designee will audit notifications of transfer twice weekly for	

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F 623	Continued From page 17 make daily life decisions. The resident was coded as requiring extensive assistance with all areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 8/22/21 that documented, "Resident was visiting with SO (significant other) and friend in parking lot. SO alerted front desk staff that resident was unresponsive and called 911. Symptoms exhibited: Writer attended to resident in parking lot and found resident dazed, pale, diaphoretic, and full-body jerking. Resident was put into reclining position in wheelchair and legs elevated. He became responsive in less than one minute. Writer brought resident back into facility and obtained VS (vital signs). BP 128/83 (blood pressure), P 164 (pulse). EMS (Emergency Medical Services) arrived and did EKG (electrocardiogram), showing ST elevation. Transfer to (name of hospital) instead of (name of another hospital) ED [emergency department] d/t (due to) EKG results and HR (heart rate) continuously >150...." Further review of the clinical record failed to reveal any evidence that the ombudsman was provided with a written notification of the hospital transfer for Resident #58. On 9/16/21 at approximately 12:30 PM, ASM #1 (Administrative Staff Member) the Administrator, stated that there was no Ombudsman notification for this hospital transfer. She stated that it was a learning opportunity regarding residents who are transferred to the emergency room and back again without being admitted to the hospital, for ensuring that, the Ombudsman should also provided this notice for those residents.	F 623	12 weeks and report findings to QAPI committee. 5. Date of compliance is 10/26/21.	

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F 623	Continued From page 18 A review of the facility policy "Notice of Transfer or Discharge" documented, "DUE TO THE REASON INDICATED BELOW A DISCHARGE OR TRANSFER FROM THIS CENTER WILL BE NECESSARY: (note, a box was next to each below option to mark the applicable option) (1) The transfer or discharge is appropriate because your health has improved sufficiently that you no longer need the services provided by this center. (2) The transfer or discharge is necessary for your welfare and your needs cannot be met in this center. (3) The safety of other individuals in this center is endangered due to your clinical or behavioral status. (4) The health of other individuals in this center is endangered due to your clinical or behavioral status. (5) You have failed to pay after appropriate notice or make arrangements for payment for services, under Medicare or Medicaid, for your stay at this center...The State long term Ombudsman will be notified by fax...." On 9/16/21 at approximately 3:30 PM, ASM #1 (Administrative Staff Member), the Administrator, and ASM #2, the Director of Nursing was made aware of the findings. No further information was provided by the end of the survey.	F 623		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to complete an accurate MDS	F 641	1.It is noted that facility staff failed to complete an accurate MDS for resident #91. Resident #91 MDS was revised and	10/26/21

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F 641	Continued From page 19 (minimum data set) assessment for one of 31 residents in the survey sample, Resident # 96. The discharge MDS assessment, with an assessment reference date of 8/12/2021, coded Resident #96, in Section A2100 - Discharge Status, as "03" indicating the resident was discharged to an acute care hospital. The clinical record documented the resident was discharged and picked up by private transport. The findings include: Resident #96 was admitted to the facility on 7/30/2021 with diagnoses that included but were not limited to: atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1), depression and cirrhosis of the liver (chronic disease condition of the liver in which fibrous tissue and modules replace normal tissue, interfering with blood flow and normal function of the organ.) (2). The discharge MDS assessment, with an assessment reference date of 8/12/2021, coded Resident #96 as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable for making daily cognitive decisions. In Section A2100 - Discharge Status, the resident was coded "03" indicating the resident was discharged to an acute care hospital. The nurse's note dated, 8/12/2021 at 9:01 a.m. documented in part, "Pt (patient) left building around 8:55 a.m. via private transport. Pt grandson pick (sic) him up named (name of	F 641	resubmitted. 2.Any resident who resides at the facility could be affected if facility staff fails to complete an accurate MDS. The last 30 days of submitted MDS assessments will be reviewed for accuracy of variances noted will be corrected. 3.The DON or designee will be educated on completing accurate MDS. 4.DON or designee will audit accuracy of MDS for 5x a week for 4 weeks and monthly x2. 5.Compliance date is 10/26/2021.	

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grandson). DC (discharge) instructions obtained, medications called in to (name of pharmacy)...Pt brought all his belongings and medication with him."

An interview was conducted with RN (registered nurse) #2, the MDS coordinator; on 9/16/2021 at 1:45 p.m., RN #2 was asked to review the nurse's note above and the discharge MDS assessment. After reviewing the above documents, RN #2 stated, "It's incorrectly coded." When asked what reference she uses to complete the MDS assessments, RN #2 stated, the RAI (Resident Assessment Instrument) manual.

The RAI manual, Version 1.17.1, dated October 2019, documented the instructions for completing Section A 2100 - Discharge Status:
Select the 2-digit code that corresponds to the resident's discharge status.
o Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home.
o Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds.
o Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons.

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F 641	Continued From page 21 The resident should have been coded, "01" for being discharged to the community. ASM #1, the administrator, ASM #2, the director of nursing, ASM # 4, the clinical services specialist and ASM #3, the director of operations, were made aware of the above concern on 9/16/2021 at 3:33 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.	F 641		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		10/26/21

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F 656	Continued From page 22 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for three of 31 residents in the survey sample, Resident's # 35, #10, and #32. The facility staff failed to develop Resident # 35's comprehensive care plan to address the care needs and diagnosis of epilepsy; failed to implement the comprehensive care plan for Resident # 10's physician ordered fluid restriction and failed to implement Resident #2's comprehensive care plan, for the use of non-pharmacological interventions prior to the	F 656	1. It is noted that facility staff failed to develop and/or implement the comprehensive care plan for resident # 35, 10, and 32. Resident #35, #10 and #32 care plan reviewed and revised. 2. Any resident who resides at the center could be affected if the facility fails to develop and/or implement a comprehensive care plan. Resident care plans will be reviewed to ensure a person-specific comprehensive care plan has been developed and implemented to meet their care needs and variances will be addressed. 1. The DON or designee will educate	

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F 656	Continued From page 23 administration of as needed pain medication. The findings include: 1. Resident # 35 was admitted to the facility with diagnoses included but were not limited to: epilepsy [1]. Resident # 35's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 07/10/2021, coded Resident # 35 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Section "I Active Diagnosis" under "Neurological" coded Resident # 35 as "I5400. Seizure Disorder or Epilepsy." The physician's orders for Resident # 35 documented in part, "Levetiracetam [2] Tablet 500 MG [milligrams]. Give 1 [one] tablet by mouth two times a day for Treat [treatment] seizures. Order Date: 7/3/2021" and "Divalproex Sodium [3] Tablet Delayed Release 250 MG. Give 1 tablet by mouth two times a day for Treat [treatment] seizure / Bipolar [4] disorder. Order Date: 7/3/2021." The comprehensive care plan for Resident # 35 dated 07/04/2021 failed to evidence a care plan to address Resident # 35's care needs for the diagnosis of epilepsy. On 09/15/21 at 3:58 p.m., an interview was conducted with RN [registered nurse] # 2, MDS coordinator. After RN #1 reviewed Resident # 35's care plan dated 07/04/2021, RN # 2 stated that there was no evidence a care plan to address Resident # 35's epilepsy. When asked	F 656	MDS, Licensed nursing staffing, nurse managers, and social workers. on developing and implementing comprehensive care plans. 2. Administrator or designee will audit comprehensive care plans weekly for 12 weeks and report findings to QAPI committee. 3. Date of compliance is 10/26/21.	

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how the comprehensive care plan is developed, RN # 2 stated that they take information from CAAs [care assessment area] of the MDS, from the interim care plan and the resident's diagnoses.

The facility's policy "Comprehensive Care Planning Process" documented in part, "The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. An interdisciplinary assessment team shall develop a comprehensive assessment and care plan for each resident based on outcomes of assessments and input from the resident, family and interdisciplinary team members. The team serves as the authority for overseeing resident care services."

On 09/14/2021 during the entrance conference at approximately 11:00 a.m., ASM [administrative staff member] # 1, administrator, was asked what professional standard the nursing staff flows. ASM # 1 stated Lippincott.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and

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with new orders..." Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

On 09/16/2021 at approximately 3:35 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, director of operations and ASM # 4, clinical service specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

[2] Used alone and along with other medications to control partial-onset seizures (seizures that involve only one part of the brain) in adults, children, and infants 1 month of age or older. Levetiracetam is in a class of medications called anticonvulsants. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a699059.html.

[3] Valproic acid [Divalproex Sodium] is used alone or with other medications to treat certain types of seizures. Valproic acid is in a class of medications called anticonvulsants. This information was obtained from the website:

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https://medlineplus.gov/druginfo/meds/a682412.html.

2. The facility failed to implement the comprehensive care plan for Resident # 10's physician ordered fluid restriction.

Resident # 10 was admitted to the facility with diagnoses included but were not limited to: end stage kidney disease [2]. Resident # 10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/13/2021, coded Resident # 10 as scoring a three [3] on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 10 for "Dialysis" while a resident.

The physician's order for Resident # 10 documented in part, "1500cc [cubic centimeter] fluid restriction as follows: 1080 cc provided on trays with meals by dietary,
420 cc provided by nursing as follows: 7-3 [7:00 a.m. - 3:00 p.m.] can give 180 cc; 3-11 [3:00 p.m. - 11:00 p.m.] can give 180 cc; 11-7 [11:00 p.m. - 7:00 a.m.] can give 60 cc. Start Date: 3/3/2021."

The comprehensive care plan for Resident #10's dated 10/17/2020 documented in part, "Focus: [Resident # 10] is nutrition at risk [sic] for weight fluctuation r/t [related to] dx [diagnosis] of moderate protein-calorie malnutrition w/increased [with increased] need secondary to ESRD [end stage renal disease] on HD [hemodialysis] 3x/week [three times per week]. R [right] leg BKA [below the knee amputation] and hx [history] of

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pressure ulcer (now resolved), hx of refusing to go to dialysis, w/need for protein supplementation, therapeutic diet and fluid restriction. Date Initiated: 10/20/2020." Under "Interventions" it documented in part, "Fluid restriction as ordered. Date Initiated: 3/3/2021."

Review of one day of meal tickets for Resident # 10 was conducted. The meal ticket documented, "Only 4.5oz [ounces] of fluid allowed" for each of the three meals, breakfast, lunch and dinner.

The POC (point of care) documentation, recorded by the staff after meal intake, for September 2021 was reviewed with the following fluid totals: 09/01/2021=1300cc [cubic centimeter], 09/05/2021=1240cc, 09/07/2021=1550cc, 09/11/2021=1300cc and 09/14/2021=1340cc.

Review of the eMAR [electronic medication administration record] for Resident # 10 dated September 2021 documented the physician's order as stated above. Further review of the eMAR revealed the following fluid amounts: 09/01/2021=240cc with a total of 1540 cc of fluid for the day, 09/05/2021=420cc with a total of 1600 cc of fluid for the day, 09/07/2021=420cc with a total of 1950 cc of fluid for the day, 09/11/2021=540ccs with a total of 1840 cc of fluid for the day and 09/14/2021=420cc with a total of 1760cc of fluid for the day.

On 09/16/2021 at 11:41 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing, regarding the monitoring of Resident # 10's fluid restrictions and Resident # 10's comprehensive care plan. When asked if the physician prescribed fluid restrictions for Resident # 10, are being

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monitored if the daily intake totals of fluid were over the physician ordered amount, ASM # 2 stated, "No." When asked if the comprehensive care plan was being implemented ASM # 2 stated no.

On 09/16/2021 at approximately 3:35 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, director of operations and ASM # 4, clinical service specialist, were made aware of the above findings.

No further information was provided prior to exit.

3. The facility staff failed to implement Resident #2's comprehensive care plan, for the use of non-pharmacological interventions prior to the administration of as needed pain medication.

Resident #32 was admitted to the facility on 5/29/2021 with a recent readmission on 6/22/2021, with diagnoses that included but were not limited to: pneumonia (1), depression, asthma (2), and a pressure injury on the sacral area (3).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/9/2021, coded Resident #32 as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living. Resident #32 was coded as requiring supervision after set up assistance was provided for eating. In Section J - Health Conditions, the resident was coded as receiving as needed pain medications for

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occasional pain.

The comprehensive care plan dated, 6/22/2021, documented, "Focus: (Resident #32) has pain or potential for pain." The "Interventions" documented, "Administer pain medications as ordered. Report s/s (signs and symptoms) potential negative side effects. Assess pain level q (every) shift and PRN (as needed) and apply interventions as needed. Assist with alternate positioning and other diversional activities to relieve pain."

The physician orders dated, 6/21/2021, documented, "Tylenol Tablet 325 mg (milligram) (Acetaminophen) (used to treat mild to moderate pain) (4) Give 2 tablet by mouth every 4 hours as needed for pain."

The August 2021 MAR (medication administration record) for Resident #32 documented the above physicians order for Tylenol and documented the Tylenol was administered on the following dates and times for the following documented pain levels:
8/18/2021 at 5:20 a.m., and 8/20/2021 at 5:50 a.m. - for pain levels of "5."
8/20/2021 at 9:10 p.m. - pain level of "7."
8/25/2021 at 5:25 a.m., 8/26/2021 at 6:20 a.m., and 8/28/2021 at 12:30 a.m. - pain levels of "5."
8/29/2021 at 1:45 p.m. - pain level of "6."

Review of the nurses noted for the dates above revealed the following documentation:
- 8/18/2021 at 5:20 a.m. documented, "Resident c/o (complained of) pain to lower abdomen, resident denies spastic pain. Pain level 5/10 (five out of a pain scale of 0 -10, ten being the worse pain ever in and zero meaning no pain)." There

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was no documentation of non-pharmacological interventions provided or offered.
- 8/20/2021 at 5:50 a.m. documented, "Resident c/o minor body aches, afebrile, and encouraged to drink fluids. Pain level 5/10." There was no documentation of non-pharmacological interventions provided or offered.
- 8/20/2021 at 9:10 p.m. documented, "Tylenol 2 tabs (tablets) for headache, pain level of 7/10." There was no documentation of non-pharmacological interventions provided or offered.
- 8/25/2021 at 5:25 a.m. documented, "Resident c/o pain to sacrum. Pain level 5/10." There was no documentation of non-pharmacological interventions provided or offered.
- 8/26/2021 at 6:20 a.m., and 8/28/2021 at 12:30 a.m., both entries documented, "Resident c/o pain to sacrum, pain level 5/10."
- 8/29/2021 at 1:45 p.m. failed to document the location of the pain or non-pharmacological interventions offered.

The September 2021 MAR for Resident #32 documented the above physicians order for Tylenol and documented the Tylenol was administered on the following dates and times for the following documented pain levels:
9/2/2021 at 12:24 p.m. and 9/3/2021 at 9:31 a.m. - pain levels of "6."
9/4/2021 at 9:28 p.m. and 9/14/2021 at 12:16 p.m. - pain levels of "5."
9/6/2021 at 12:08 p.m., 9/7/2021 at 8:26 a.m., 9/10/2021 at 1:41 p.m., and 9/12/2021 at 8:20 p.m. - pain levels of "6."

Review of the nurse's notes for the dates above revealed the following:
9/2/2021 at 12:24 p.m., 9/3/2021 at 9:31 a.m.,

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9/4/2021 at 9:28 p.m.,9/6/2021 at 12:08 p.m.,9/10/2021 at 1:41 p.m., 9/7/2021 at 8:26 a.m., 9/12/2021 at 8:20 p.m., all failed to evidence documentation of the location of the pain and if non-pharmacological interventions were attempted or offered. The nurse's note dated, 9/14/2021 at 12:16 p.m. documented, "Resident complained of pain to right knee. On the pain scale of 1 -10, she stated it is a 5/10." There was no documentation if non-pharmacological interventions were offered.

An interview was conducted with LPN (licensed practical nurse) #1, on 9/16/2021 at 10:30 a.m. When asked the purpose of the care plan, LPN #1 stated it's for us to have interventions for the resident. When asked if the care plan should be followed, LPN #1 stated, yes.

ASM #1, the administrator, ASM #2, the director of nursing, ASM # 4, the clinical services specialist and ASM #3, the director of operations, were made aware of the above concern on 9/16/2021 at 3:33 p.m.

No further information was provided prior to exit.

References:
(1) Pneumonia: An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. This information was obtained from the following website: https://medlineplus.gov/pneumonia.html.
(2) Asthma: respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman,

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F 656	Continued From page 32 page 51. (3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html	F 656		
F 657 SS=E	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	F 657		10/26/21

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F 657	Continued From page 33 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 by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and revise the care plan for three of 31 residents in the survey sample, Residents #64, #297, and #63. 1. The facility staff failed to revise the comprehensive care plans for Residents #64 and #297 following a resident to resident incident between them on 5/8/21. 2. The facility staff failed to revise Resident #63's care plan when he began taking an antidepressant medication. The findings include: 1. Resident #64 was admitted to the facility on 7/25/18 with diagnoses including a femur fracture, bipolar disorder (1), epilepsy (2), alcohol abuse, and nicotine dependence. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/3/21, Resident #64 was coded as having no cognitive impairment for making daily decisions,	F 657	1. It is noted that facility staff failed to review and revise the care plan for resident #64, 297. And 63. Resident # 63 and #64 care-plan reviewed and revised and #297 no long resides in the center. 2. Any resident who resides at the center could be affected if facility staff fail to review and revise care plans. Resident's care plans will be reviewed with change of condition and their next scheduled assessment and revised accordingly to reflect care needs. 3. The DON or designee will educate MDS, Licensed nursing staffing, nurse managers, and social workers reviewing and revising of care plans. 4. Administrator or designee will audit care plans weekly for 12 weeks and report findings to QAPI committee. 5. Date of compliance is 10/26/21.	

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having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having demonstrated no mood disorder symptoms, no psychosis, no behaviors toward himself or others, no rejection of care, and no wandering. He was coded as being independent in all ADLs (activities of daily living), as having no functional limitations with range of motion in upper or lower extremities, and as always continent of both bladder and bowel. He was coded as using a wheelchair for locomotion during the look back period.

Resident #297 no longer resides in the facility. She was admitted on 4/19/21 and discharged on 5/15/21. She was admitted with diagnoses including urinary tract infection, COPD (3), and anxiety disorder. On the most recent MDS, an admission assessment with an ARD of 4/26/21, she was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS. She was coded as being completely dependent on facility staff for all ADLs, and as using a wheelchair for locomotion.

A review of Resident #64's clinical record revealed the following progress notes:

"5/8/2021 12:31 (12:31 p.m.) *Behavior Note Behavior Observed (Onset and Duration): Resident walked out of the facility in the morning without using wheel-chair, he came back with signs of being intoxicated. At around 1030 (10:30 a.m.), resident noted with extreme agitation, tried to hit staff and the writer. Writer tried to calm resident down and redirect him, but resident was not cooperative, writer called 911 for help. Police officer stayed with resident for about 45 minutes

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and recommended writer to call family and MD (medical doctor) for a quick discharge, because of safety concerns of the staff and other employees. Police officers told writer that resident stated: 'I don't want to be here.' Family and MD notified."

"5/8/2021 13:09 (1:09 p.m.) Social Services Note Late Entry: Note Text: 05/08/2021, at approximately 9:30 p.m. [local police department] arrived to serve ECO (emergency custody order) which was approved by magistrate. Resident completed a virtual evaluation with [local CSB (community services board) Representative with [local police department] present."

"05/08/2021 at approximately 9:50 p.m. SS [social services] Care Coordinator (SSCC) spoke with [name CSB representative]. SSCC provided [CSB representative] with a hx (history) of Resident's behavior and actions on 05/08/2021 along with a hx of his medical condition, mental illness, and suspected substance abuse. [CSB representative] shared that during the evaluation, Resident denied having a mental illness dx (diagnosis) and denied substance abuse. [CSB representative] shared that she would have her Supervisor review her evaluation and give SSCC a call back. 05/08/2021 at approximately 11 p.m. SSCC received phone call from [CSB representative]. She shared that her Supervisor determined that Resident does not meet ECO criteria."

5/8/2021 16:14 (4:14 p.m.) *Behavior Note Behavior Observed (Onset and Duration): Cna (certified nursing assistant) reported to writer that she observed resident slamming his wheelchair into the same resident [Resident #297]

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wheelchair multiple times. Cna also stated resident had enough room to pass around the resident without slamming the wheelchair."

A review of Resident #64's comprehensive care plan dated 7/25/18 and most recently updated 8/16/21 revealed no evidence of this incident.

A review of Resident #297's comprehensive care plan dated 4/20/21 revealed no evidence of this incident.

On 9/15/21 at 1:58 p.m., ASM (administrative staff member) #1, the administrator, and ASM #4, the clinical services specialist, were interviewed. ASM #1 stated there was no evidence of updates to either resident's care plan following the incident.

On 9/16/21 at 9:51 a.m., ASM #1, ASM #3, the clinical services specialist, and ASM #4, director of operations, were informed of these concerns.

On 9/16/21 at 10:31 a.m., LPN (licensed practical nurse) #1 was interviewed. When asked the purpose of a care plan, she stated the care plan is in place to have interventions to meet the residents' needs. When asked who is responsible for updating the care plan as changes develop with residents, she stated it is primarily the nursing staff - unit supervisor, assistant director of nursing or director of nursing. She stated a resident to resident incident should be added to both residents' care plans.

On 9/16/21 at 11:41 a.m., ASM #2 was interviewed. When asked the purpose of a care plan, he stated the care plan is a guide to help staff take care of a resident with their own

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specific problems and interventions. He stated the care plan is an "ongoing document" and involves all disciplines who provide care and services for the resident. He stated a resident to resident incident should be included on the care plan for both residents involved.

A review of the facility policy, "Comprehensive Care Planning Process," revealed, in part: "Duties and responsibilities of the Care Planning/Interdisciplinary Team include, but are not limited to: Reviewing care plans to assure that: They reflect the resident's medical and nursing assessment; They attempt to manage risk factors."

No further information was provided prior to exit.

(1) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) "The epilepsies are a spectrum of brain disorders ranging from severe, life-threatening and disabling, to ones that are much more benign. In epilepsy, the normal pattern of neuronal activity becomes disturbed, causing strange sensations, emotions, and behavior or sometimes convulsions, muscle spasms, and loss of consciousness." This information is taken from the website https://www.ninds.nih.gov/Disorders/All-Disorders/Epilepsy-Information-Page.

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(3) "COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. COPD can cause coughing that produces large amounts of a slimy substance called mucus, wheezing, shortness of breath, chest tightness, and other symptoms." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/copd.

2. Resident #63 was admitted to the facility on 4/5/21, and was most recently readmitted on 5/17/21, with diagnoses including congestive heart failure (1), diabetes (2), and bipolar disorder (3). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/2/21, Resident #63 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having received an antidepressant on all seven days of the look back period.

A review of Resident #64's physician orders revealed the following order: "Mirtazapine (4) Tablet 7.5 MG (milligrams). Give 1 tablet by mouth at bedtime for Depression. Start Date 06/03/2021."

A review of Resident #63's MARs (medication administration records) from 6/4/21 through 9/14/21 revealed he had received the Mirtazapine as ordered.

A review of Resident #63's comprehensive care plan, dated 4/26/21 and revised 7/16/21, revealed no evidence that it had been updated to include

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Resident #63's receiving the Mirtazapine.

On 9/16/21 at 10:31 a.m., LPN (licensed practical nurse) #1 was interviewed. When asked the purpose of a care plan, she stated the care plan is in place to have interventions to meet the residents' needs. When asked who is responsible for updating the care plan as changes develop with residents, she stated it is primarily the nursing staff - unit supervisor, assistant director of nursing or director of nursing. She stated a resident's care plan should be updated when the resident begins receiving an antidepressant.

On 9/16/21 at 11:41 a.m., ASM #2 was interviewed. When asked the purpose of a care plan, he stated the care plan is a guide to help staff take care of a resident with their own specific problems and interventions. He stated the care plan is an "ongoing document" and involves all disciplines who provide care and services for the resident. He stated a resident's care plan should be updated to include the resident's receiving an antidepressant.

On 9/16/21 at 9:51 a.m., ASM (administrative staff member) #1, he administrator, ASM #3, the director of operations, and ASM #4, the clinical services specialist, were informed of these concerns.

No further information was provided prior to exit.

(1) "Heart failure is a condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body...As the heart's pumping becomes less effective, blood may back up in other areas of the body. Fluid

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F 657	Continued From page 40 may build up in the lungs, liver, gastrointestinal tract, and the arms and legs. This is called congestive heart failure." This information is taken from the website https://medlineplus.gov/ency/article/000158.htm (2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (3) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (4) "Mirtazapine tablets are indicated for the treatment of major depressive disorder." This information is taken from the website https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0039f505-7cd0-4d79-b5dd-bf2d172571a0.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		10/26/21

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F 684	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to ensure physician ordered fluid restrictions were implemented and monitored per physicians orders for two of 31 residents in the survey sample, Resident # 10 and #33. The facility staff failed to ensure physician ordered fluid restrictions for Resident #10 and #33 were implemented and monitored to ensure the physician amount of fluids were provided. The findings include: 1. Resident # 10 was admitted to the facility with diagnoses included but were not limited to end stage kidney disease [2]. Resident # 10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/13/2021, coded Resident # 10 as scoring a three [3] on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 10 for "Dialysis" while a resident. The physician's order for Resident # 10 documented in part, "1500cc [cubic centimeter] fluid restriction as follows: 1080 cc provided on trays with meals by dietary 420 cc provided by nursing as follows: 7-3 [7:00 a.m. - 3:00 p.m.] can give 180 cc; 3-11 [3:00 p.m. - 11:00 p.m.] can give 180 cc; 11-7 [11:00 p.m. - 7:00 a.m.] can give 60 cc. Start Date: 3/3/2021." The comprehensive care plan for Resident #10's	F 684	1. It is noted that facility staff failed to ensure physician ordered fluid restrictions were implemented for #10 and #33. Resident #10 and #33 physician notified that fluid restriction order was not followed no untoward effects of residents. 2. Any resident who resides in the facility could be affected if physician ordered fluid restrictions were not followed. A review of all residents with fluid restrictions order will be to ensure physician order followed any variances will be report the resident physician. 3. The Don or Designees will educate licensed nurses, C.N.A□s, therapy , and dietary department on fluid restriction policy and following physician ordered fluid restrictions. 4. DON or designee will audit fluid restriction practices 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 5. Compliance date is 10/26/21.	

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dated 10/17/2020 documented in part, "Focus: [Resident # 10] is nutrition at risk [sic] for weight fluctuation r/t [related to] dx [diagnosis] of moderate protein-calorie malnutrition w/increased [with increased] need secondary to ESRD [end stage renal disease] on HD [hemodialysis] 3x/week [three times per week]. R [right] leg BKA [below the knee amputation] and hx [history] of pressure ulcer (now resolved), hx of refusing to go to dialysis, w/need for protein supplementation, therapeutic diet and fluid restriction. Date Initiated: 10/20/2020." Under "Interventions" it documented in part, "Fluid restriction as ordered. Date Initiated: 3/3/2021."

Review of one day of meal tickets for Resident # 10 was conducted. The meal ticket documented, "Only 4.5oz [ounces] of fluid allowed" for each of the three meals, breakfast, lunch and dinner.

The POC (point of care) documentation, recorded by the staff after meal intake, for September 2021 was reviewed with the following fluid totals: 09/01/2021=1300cc, 09/05/2021=1240cc, 09/07/2021=1550cc, 09/11/2021=1300cc and 09/14/2021=1340cc.

Review of the eMAR [electronic medication administration record] for Resident # 10 dated September 2021 documented the physician's order as stated above. Further review of the eMAR revealed the following fluid amounts: 09/01/2021=240cc with a total of 1540 cc of fluid for the day, 09/05/2021=420cc with a total of 1600 cc of fluid for the day, 09/07/2021=420cc with a total of 1950 cc of fluid for the day, 09/11/2021=540ccs with a total of 1840 cc of fluid for the day and 09/14/2021=420cc with a total of 1760cc of fluid for the day.

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On 09/16/2021 at 11:41 a.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing, regarding the monitoring of Resident # 10's fluid restrictions. When asked which staff is responsible for keeping up with the totals of the resident's fluid intake each day, ASM # 2 stated that nurse should be looking at it at the end of each shift. After ASM #2, reviewed the point of care documentation and eMAR for Resident # 10's fluid intakes and missing daily totals, ASM # 2 stated that that it is likely a function of PCC [point click care - the electronic health record]. When asked if the fluid restrictions were being implemented and monitored as ordered, if the daily intake totals were over the physician ordered amount ASM # 2 stated, "No."

On 09/16/2021 at approximately 3:35 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, director of operations and ASM # 4, clinical service specialist, were made aware of the above findings.

No further information was provided prior to exit.
2. Resident #33 was admitted to the facility on 12/16/20, and most recently readmitted on 1/17/21, with diagnoses including ESRD (end stage renal disease) (1), diabetes (2), and CHF (congestive heart failure) (3). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/5/21, Resident #33 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as having received dialysis during the look back

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period.

On 9/15/21 at 9:08 a.m., Resident #33 was observed sitting up in her bed eating breakfast. When asked about the items on her tray, she stated the facility staff usually provides items on her tray that are healthy for her kidneys. When asked about her fluid intake and if the facility is keeping up with her fluid intake, she stated: "I really don't think so." She stated the staff "almost never" asked her about how much she had to drink during a shift. She stated she is supposed to have orders for a fluid restriction because of her low kidney function.

A review of Resident #33's physician orders revealed the following orders:
"1200cc (cubic centimeter) fluid restriction as follows: 840 cc provided on trays with meals by dietary; 360 cc provided by nursing as follows: 7-3 can give 150 cc; 3-11 can give 150 cc; 11-7 can give 60 cc. For fluid volume maintenance. And encourage resident to comply with Physician prescribed order. Start Date 03/04/2021."

A review of Resident #33's MARs (medication administration records) for September 2021 revealed a documented amount of fluid consumed by the resident for first, second, and third shifts each day.

A review of Resident #33's POS (point of service) documentation for September 2021 contained an additional amount of fluid consumed by the resident for first, second, and third shifts each day.

A review of Resident #33's daily meal tickets revealed she was given 120 ccs of liquid at

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breakfast, lunch, and dinner.

Further review of Resident #33's clinical record revealed no evidence of a total amount of fluid consumed by her each day (the amount recorded in the MAR plus the amount recorded in the POS documentation).

On the following dates, Resident #33 exceeded her 1200 cc fluid restriction with the totals:

9/1/21 - 1310 cc [cubic centimeter]s
9/2/21 - 1730 ccs
9/4/21 - 1580 ccs
9/5/21 - 1300 ccs
9/9/21 - 2230 ccs
9/10/21 - 1650 ccs
9/11/21 - 1510 ccs
9/12/21 - 1560 ccs
9/14/21 - 1760 ccs

A review of Resident #33's comprehensive care plan dated 3/27/21 revealed, in part: "[Resident #33] has renal disease requiring dialysis...Encourage to adhere to fluid restrictions as recommended or ordered...."

On 9/15/21 at 3:25 p.m., CNA (certified nursing assistant) #8 was interviewed. She stated the nurse tells her how much fluid a resident may consume during her shift. She stated this amount includes the amount of fluids included on the resident's meal tray. CNA #8 stated the dietary ticket for each meal details how much fluid a resident gets on their meal tray. She stated she documents this amount at the end of each shift on the POS record in the electronic medical record. She stated she does not do a total for the whole day for the resident. CNA #8 stated the

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amount she documents does not include the amount a nurse will give as a part of the nursing documentation.

On 9/16/21 at 10:31 a.m., LPN (licensed practical nurse) #1 was interviewed. She stated the CNAs document how much fluid a resident consumes during a shift to include free fluids, and the amount of fluid on a meal tray. LPN #1 stated the resident's order states how much free water/meal tray fluids a resident may consume, and how much she may give as part of medication pass. She stated she documents only what she administers the resident on the MAR. She stated the CNA documents what they give on the POS record. LPN #1 stated she is not aware of anyone doing any kind of total of fluids from both the MAR and the POS documentation.

On 9/16/21 at 11:41 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed regarding fluid restriction monitoring. When asked who should be keeping up with the total amount of fluid a resident consumes in a 24 hour period, ASM #2 stated, "The nurse should be looking at it at the end of each shift." When asked about the total for all three shifts, he stated he was not aware this was happening. He stated this is likely caused by the way the electronic medical record software is structured. When shown Resident #33's totals for September 2021, ASM #2 stated he cannot say the resident's fluid intake is being monitored because it is not being totaled.

On 9/16/21 at 3:33 p.m., ASM #1, the administrator, ASM #2, ASM #3, the director of operations, and ASM #4, the clinical services specialist, were informed of these concerns.

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F 684	Continued From page 47 No further information was provided prior to exit. References: (1) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website https://medlineplus.gov/ency/article/000500.htm. (2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (3) "Heart failure is a condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body...As the heart's pumping becomes less effective, blood may back up in other areas of the body. Fluid may build up in the lungs, liver, gastrointestinal tract, and the arms and legs. This is called congestive heart failure." This information is taken from the website https://medlineplus.gov/ency/article/000158.htm	F 684		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		10/26/21

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F 689	Continued From page 48 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide care and services to promote a safe environment for three of 31 residents in the survey sample, Residents #64, #297, and #35. 1. Resident #64 was repeatedly allowed to leave the facility unsupervised without being assessed for safety to do so, and without being educated by the facility regarding the risks of suffering a serious injury while out of the facility without supervision. On 5/8/21, Resident #64 rammed his wheelchair into Resident #297's wheelchair multiple times while Resident #297 was seated in her wheelchair. The facility failed to assess Resident #297 for injury, and failed to implement interventions to ensure a safe environment and the safety of Resident #297. The facility failed to perform urine and/or blood screening tests for alcohol and illegal drugs on Resident #64 on multiple occasions when the resident displayed symptoms of impairment, despite having entered into an agreement with the resident to do so. 2. The facility staff failed to wrap Resident # 35's right and left bedrails with a towel for seizure precautions according to the physician's orders. The findings include: 1. Resident #64 was admitted to the facility on 7/25/18 with diagnoses including a femur fracture, bipolar disorder (1), epilepsy (2), alcohol abuse, and nicotine dependence. On the most recent	F 689	1.1a) It is noted that facility failed to assess Resident #297 for injury, and failed to implement interventions to ensure a safe environment resident no longer resides in center. 1b) The facility failed to perform urine and/or blood screening tests for alcohol and illegal drugs on Resident #64 on multiple occasions when the resident displayed symptoms of impairment, despite having entered into an agreement with the resident to do so. Resident #64 care agreement was reviewed and revised on 9/16/21 1c) The facility staff failed to wrap Resident #35's right and left bedrails with a towel for seizure precautions according to the physician's orders. #35 bedrails wrapped on 9/16/2. 1d) Resident #64 was issued a 5-day discharge on 9/16/21 and going through the appeals process. Patient is currently in the appeals process with hearing date of 10/25/21. Patient was placed on 1 to 1 supervision on 9/16/21. A behavior contact was initiated 9/24/21 with weekly review of behavior contact. 1e) Resident #64 was evaluated and no longer is allowed unsupervised independent therapeutic leave. 2.2a) Any resident who resides at the center could be affected if the facility staff fails to assess residents for injury. A 14day review of the 24-hour report and incidents reports will be reviewed to	

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F 689	Continued From page 49 MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/3/21, Resident #64 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having demonstrated no mood disorder symptoms, no psychosis, no behaviors toward himself or others, no rejection of care, and no wandering. He was coded as being independent in all ADLs (activities of daily living), as having no functional limitations with range of motion in upper or lower extremities, and as always continent of both bladder and bowel. He was coded as using a wheelchair for locomotion during the look back period. Resident #297 no longer resides in the facility. She was admitted on 4/19/21 and discharged on 5/15/21. She was admitted with diagnoses including urinary tract infection, COPD (3), and anxiety disorder. On the most recent MDS, an admission assessment with an ARD of 4/26/21, she was coded as being severely cognitively impaired for making daily decisions, having scored seven out of 15 on the BIMS. She was coded as being completely dependent on facility staff for all ADLs, and as using a wheelchair for locomotion. On 9/15/21 at 8:30 a.m., Resident #64 was observed standing in the hallway near the nurses' desk. He walked from the nurses' desk through the day room, and stepped out into the courtyard. On 9/15/21 at 11:22 p.m., Resident #64 was observed sitting in the day room in a wheelchair. A review of Resident #64's physician's orders	F 689	ensure staff assessed for injury any variances will be corrected. 2b) Any resident that has agreement to obtain urine and/or blood screening tests for alcohol and illegal drugs is at risk. A 100% audit will be complete of any resident with order to obtain urine or blood screening related to alcohol or illegal drugs will be complete any variance will be report to physician. 2c) Any resident with diagnosis of seizure activity is at risk of not having safety device in place to prevent injury. A 100% audit of residents with diagnosis of seizure activity will be conducted to ensure that safety devices are in place to prevent injury. 2d) Any resident is a risk of another resident returning from outing/LOA with untoward behaviors that effect other residents. A review of the last 30days of residents nursing documentation that went out on LOA/outing for any untoward behaviors toward other residents will be completed any variance will be report to physicians and patients plan of care adjusted. 2e) An audit of all current residents was completed, no additional residents identified as requesting independent therapeutic leave.	

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F 689	Continued From page 50 revealed the following order: "7/25/18 Topiragen Tablet (Topiramate) 50 mg. Give 3 tablets by mouth two times a day for Seizures." A review of Resident #64's clinical record revealed the following progress notes: 4/18/2021 17:15 (5:15 p.m.) *Behavior Note Behavior Observed (Onset and Duration): At 1610 (4:10 p.m.), resident was verbally abusive and yelling at high volume at the writer, threatening to break and entering the writer's office by force. Resident entered the office and he was instructed to get out of the office. Writer told resident that his behavior was not acceptable. Resident appeared more drunk (sic), he had a bottle in his jacket which he could not (sic) writer to see what was in the bottle." "4/19/2021 23:50 (11:50 p.m.) Health Status Note Text: Nurse writing this report was called CNA in [Resident #64's room] and found resident sitting on the floor closed to his bed seizuring (sic) ...continuing monitoring resident for seizure precaution." "4/28/2021 00:09 (00:09 a.m.) Health Status Note Text: Resident went out for dental appt (appointment) today, when he came back around 1800 (6:00 p.m.) smell like a alcohol (sic) from him. I didn't saw (sic) him to drink but just smell like a alcohol. No other episode observed other than smell." "5/1/2021 13:12 (1:12 p.m.) Health Status Note Text: resident signed out @ (at) 08:45 am and came back @ 10:00 am. couple hour later resident was smelling (like) alcohol and became talkative, bothering everyone in the unit. witness	F 689	3.3a) The DON or designee will be educated licensed nurse on assessment of injury and implementation of intervention to ensure safe environment. 3b The DON or designee will educate licensed nurses on following physician orders related to drug and alcohol screening. 3c) The DON or designee will educate licensed nurse and C.N.A on placement of devices for patient with seizure activity. 3d) The DON or designee will educate all staff on the completion of leave of absence/outing form that includes education the resident on safety risk prior to leaving center. When residents return from outing/LOA that present untoward behaviors toward other residents will be assessed and physician notified plan of care will be adjusted accordingly. 3e) The DON or designee will educate social work and licensed nurse on any newly identified resident expressing the desire for independent therapeutic leave will be evaluate for safety prior to independent therapeutic leave. 4.4a) DON or designee will audit 24 hour report and incident report to ensure staff assessed for injury 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 4b) DON or designee will audit patient with orders to obtain urine and/or blood screening to ensure orders are completed 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 4c) Don or designee will audit residents	

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F 689	Continued From page 51 fall in [unit name] living room by students CNA. Resident refused to be assess by nurse." "5/1/2021 23:06 (11:06 p.m.) *Behavior Note Behavior Observed (Onset and Duration): resident had alcohol smell all over today after coming back for his shopping at [local grocery store]. Was talkative and provoking staff members." "5/8/2021 12:31 (12:31 p.m.) *Behavior Note Behavior Observed (Onset and Duration): Resident walked out of the facility in the morning without using wheel-chair, he came back with signs of being intoxicated. At around 1030 (10:30 a.m.), resident noted with extreme agitation, tried to hit staff and the writer. Writer tried to calm resident down and redirect him, but resident was not cooperative, writer called 911 for help. Police officer stayed with resident for about 45 minutes and recommended writer to call family and MD (medical doctor) for a quick discharge, because of safety concerns of the staff and other employees. Police officers told writer that resident stated: 'I don't want to be here.' Family and MD notified." "5/8/2021 13:09 (1:09 p.m.) Social Services Note Late Entry: Note Text: 05/08/2021, at approximately 9:30 p.m. [local police department] arrived to serve ECO (emergency custody order) which was approved by magistrate. Resident completed a virtual evaluation with [local CSB (community services board) Representative with [local police department] present." "05/08/2021 at approximately 9:50 p.m. SS (social services) Care Coordinator (SSCC) spoke with [name CSB representative]. SSCC provided	F 689	with a diagnosis of seizure disorder that require a safety device to be in place to prevent injury 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 4d a) The DON or designee will audit residents nursing documentation that went out on LOA/outing for any untoward behaviors toward other residents to ensure that physician notification occurred, resident assessment, and patients plan of care adjusted 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. b) The DON or designee will audit outing/LOA forms to ensure resident signs out and education was provided on safety risk 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 4e) The DON or designee will audit social services admission assessment to determine if resident has a desire to have independent therapeutic leave and that the independent therapeutic leave evaluation is complete 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 5. Compliance date is 10/26/21.	

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[CSB representative] with a hx (history) of Resident's behavior and actions on 05/08/2021 along with a hx of his medical condition, mental illness, and suspected substance abuse. [CSB representative] shared that during the evaluation, Resident denied having a mental illness dx (diagnosis) and denied substance abuse. [CSB representative] shared that she would have her Supervisor review her evaluation and give SSCC a call back. 05/08/2021 at approximately 11 p.m. SSCC received phone call from [CSB representative]. She shared that her Supervisor determined that Resident does not meet ECO criteria."

5/8/2021 16:14 (4:14 p.m.) *Behavior Note Behavior Observed (Onset and Duration): Cna (certified nursing assistant) reported to writer that she observed resident slamming his wheelchair into the same resident [Resident #297] wheelchair multiple times. Cna also stated resident had enough room to pass around the resident without slamming the wheelchair."

A review of Resident #64's comprehensive care plan dated 7/25/18 and most recently updated 8/16/21 revealed, in part: "Resident #64 is at risk of a change/decline in his mood and/or psychosocial status d/t (due to) continuing ETOH abuse, nicotine dependence, hx of aggressive/intimidating behavior toward elderly residents, being younger than the general population...Encourage and allow to ventilate feelings...Mental Health Consult... ." The care plan did not evidence any documentation regarding or addressing the incident with Resident #297 on 5/8/21.

A review of Resident #297's clinical record

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revealed no evidence of documentation regarding this incident, and no evidence that Resident #297 was assessed for injury following this incident. A review of Resident #297's comprehensive care plan dated 4/20/21 revealed no evidence of this incident, or any interventions for ensuring a safe environment and Resident #297's safety from Resident #64.

Further review of Resident #64's clinical record revealed the following progress notes:

"5/8/2021 18:32 (6:32 p.m.) Social Services Note Text: 05/08/2021, 5:15 p.m. SS Care Coordinator met with magistrate at Prince William County Adult Detention Center in Manassas, VA. SSCC submitted a petition for ECO (Emergency Custody Order) for Resident, [name of Resident #64] due to his attempt to physically harm staff members and other elderly residents at the center on the morning of 05/08/2021. Center awaits magistrate's decision to deny or grant the ECO."

"05/08/2021, 6:15 p.m. SSCC arrived at the center to assess the situation in regard to Resident's behavior. Resident prompted conversation with SSCC. Resident was noted to have dilated pupils, unable to finish his thoughts, repeating himself often, and easily distracted. Resident rambled on about the events that occurred earlier in the day; however, Resident's thoughts remained scattered. Staff will continue to monitor Resident closely due his unpredictable and abrasive/threatening behavior and demeanor."

"5/12/2021 20:05 (8:05 p.m.) Fall Note Data: Resident complained of pain in his left shoulder and left side of his chest, when i (sic) asked what

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happened he says 'I fell down early Tuesday from the bed.' Action: Did assessment, resident has cut on his scalp behind left ear, can't fully lift his left hand. Resident doesn't remember exact time when it happened because he was dreaming. Neurocheck initiated...Notified, MD, got orders for chest x-ray and Left shoulder x-ray."

"5/12/2021 20:23 (8:23 p.m.) Health Status Note Text: Resident stated that he fell down from his bed on Tuesday early morning, was complaining on pain in his left side of chest, left shoulder and cut on his head."

"5/14/2021 11:30 (11:30 a.m.) Social Services Note Late Entry: Note Text: IDT (interdisciplinary team) conducted Care Plan Meeting with Resident to discuss behavior management. IDT Members present for meeting include: Administrator, DON (director of nursing), ADON (assistant director of nursing), SS (social services) Care Coordinator, Psych (psychiatry) NP (nurse practitioner), and Psychologist. Resident denied being verbally or physically aggressive toward staff or other residents on 05/08/2021. When asked why the police were called on [5/8/21], Resident stated it was because he and ADON do not get along; then he changed the subject. Resident denied consuming alcohol and denied using any other substances. When asked why his behavior and overall demeanor are significantly different after he returns from LOA, Resident could not provide an answer. When asked why he smells of alcohol and has increase in falls after returning from LOA, Resident could not provide an answer.
At the conclusion of the meeting, Resident agreed to the following:
-Allowing staff to search his room and personal

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belongings at any time as long as he is present.
-Providing blood or urine for toxin screen to be completed.
-Going on LOA only during Monday through Friday between the hours of 8 a.m. to 4 p.m."

"5/14/2021 13:26 (1:26 p.m.) Psych (psychiatry) Note Late Entry: Note Text: Psychiatric Progress Note
Chief Complaint: Patient seen to evaluate mental status and adjust medications for behavioral disturbance
Chief Complaint Comments: Care plan meeting with the patient relating his escalated behavior issues
History of Present Illness
[Resident #64] is seen on 5/14/2021 for care plan meeting regarding patient escalated behavior issues recently.
The meeting was held in conference room with the patient in presence of this provider, psychologist, SW (social service care coordinator), DON, ADON, and facility administrator. The patient has shown behavior concern especially in the weekend for past couple of weeks. Per staff notes he goes out of the facility and when he comes back to the facility "Resident was noted to have dilated pupils, unable to finish his thoughts, repeating himself often, and easily distracted". Reported he has agitated behavior towards the staff and other resident in the facility. Patient denied being intoxicated with any alcohol or substance abuse while he is in the facility. Upon
asking about cause of his agitation he talks about random things and avoided conversation focused on alcohol intake or substance use (patient has a history of alcohol abuse, crystal meth and cocaine use). He is noted to be

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defensive for any questions asked and had a perseverative thoughts. Per staffs he has been refusing medical services including outpatient referrals and lab [laboratory] works. At the end of the meeting patient agreed to comply with the purposed facility protocol, and agreed with lab works. No overt symptoms suggestive of depression, SI/HI [suicidal ideation/homicidal ideation], and hallucination noted. He reported having a fair appetite and sleep at night. Chart and medication reviewed.
Pt has Hx of ETOH abuse and may possibly be buying ETOH. Discussed risks of using ETOH with pt.
Mental Status Exam
Attitude: Defensive, Guarded
Appearance: Appropriate, Thin Habitus
Behavior: Intrusive
Speech: Hyperverbal
Gait: Wheel Chair but walks, says uses w/c d/t [wheel chair due/to] seizure concerns
Mood: Irritable
Affect: Labile
Thought process: Circumstantial
Thought Content: No hallucinations, grandiose delusions
Suicidality: None/denies
Homicidality: None/denies
Insight/Judgement: Poor
Diagnosis Substance Induced Mood Disorder - F19.94 Bipolar Disorder ' Mixed ' Unspecified - F31.6 Anxiety
Disorder Secondary to Medical Conditions - F06.4
Alcohol abuse uncomplicated- F10.10
Nicotine Dependence unspecified-F17.200
Treatment Plan / Recommendations
Plan: Supportive therapy provided. Psychiatric team will monitor mood and behavior, Performance measures Neuropsychiatric

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symptoms reviewed, Patient is encouraged to participate in activities on the unit
Continue psychotherapy
Patient motivated to verbalized any concerns at any time with the staffs
Will continue to monitor his mood and behavior."
This note was signed by OSM #6, the psychiatric NP (nurse practitioner)."

"6/17/2021 15:49 (3:49 p.m.) Health Status Note Text: 06/17/21 at 1549 (3:49 p.m.) Resident started episode of epilepsy near nursing station during this shift put resident safe position with blanket under head side lying position and ends at 1600 (4:00 p.m.)."

"7/22/2021 15:37 (3:37 p.m.) Fall Note Data: At 1506 (3:06 p.m.) resident was in courtyard when he had seizure and fell down from his wheelchair and hit his head on concrete (other resident witnessed the fall)...His mother and MD was informed, got order to send to ER (emergency room) for evaluation. Called 911."

"7/22/2021 19:27 (7:27 p.m.) Health Status Note Text: At 1506 (5:06 pm) resident was found in courtyard lying on the ground having seizure. Other resident saw him how he fell down from the wheelchair and hit his head, there was loud sound...Got report from morning nurse that resident was out earlier in the [local convenience store], when he came back, she smelled alcohol. His mother and MD was notified. Got order to send to ER for evaluation."

"7/22/2021 19:36 (7:36 p.m.) Health Status Note Text: At 18.45 (6:45 p.m.) got report from (local hospital) that patient going back, he has Aberration of Left hand, contusion of Left hand,

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head injury...bloodwork for alcohol and drugs was negative."

"8/2/2021 16:52 (4:52 p.m.) Health Status Note Text: Resident face is red, flashed when he was passing me by. i (sic) smelled alcohol from him. Morning nurse gave me report that earlier in the morning he was out."

"8/2/2021 20:43 (8:43 p.m.) Health Status Note Text: At 18.50 (6:50) pm resident was cursing calling me 'Bitch' he would come into nursing station, aggressive and yelling, supervisor asked him to leave area, he got up from his wheelchair and started going onto him, repeating 'What's you gonna do' threatening him. So supervisor told me to call 911. When later at 19.15 policemen came they talked to me, to resident and supervisor."

"9/16/2021 01:48 1:48 a.m.) Health Status Note Text: Noted resident to smell heavily of alcohol, face is red, speech is slurred, pupils dilated, and resident is rambling loudly and rapidly in incoherent speech. Resident has been going in and out of his room, then outside to the courtyard. When he comes back in building, his behavior is escalated. Resident refuses to allow staff to search his room. Unable to redirect."

Further review of Resident #64's clinical record failed to reveal any evidence that he had been assessed for safety to leave the facility unsupervised, given his history of seizures and falls. The review failed to reveal evidence that the facility had put interventions in place to protect the resident from injury when he left the facility unsupervised.

The review failed to reveal any evidence that the

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facility staff had educated Resident #64 on the risks for falls and seizures occurring out in the community when he left the facility unsupervised. The review failed to reveal evidence that Resident #64 had received further psychological/psychiatric services after 5/14/21, prior to 9/15/21.

The review failed to reveal any evidence that the facility had chosen to take action on the verbal agreement made between the facility and the resident subsequent to the 5/14/21 IDT meeting, other than a urine and blood screening performed by an outside hospital when the resident was sent to the emergency room for a possible fracture on 7/22/21.

Further review of Resident #64's comprehensive care plan dated 7/25/18 and most recently updated 8/16/21 revealed, in part: "[Resident #64] has had actual falls with injuries noted, and remains at risk of falling in the future d/t (due to) disease process/seizure diagnosis. Resident non-compliant (with) safety measures ...Continue with rounding frequently to check on resident and offer help as needed ...Anticipate and meet needs as possible ...[Resident #64] has seizures r/t (related to) epilepsy ...Give seizure medication as ordered by doctor ...observe for seizure activity and report to MD ...SEIZURE PRECAUTIONS Do not leave resident alone during a seizure, protect from injury, if resident is out of bed, help to the floor to prevent injury. Remove or loosen tight clothing, don't attempt to restrain resident during a seizure as this could make the convulsions more severe. Protect from onlookers, draw curtains."

On 9/15/21 at 1:58 p.m., ASM (administrative staff member) #1, the administrator, and ASM #4,

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the clinical services specialist, were interviewed. When asked if the facility had submitted a FRI (facility reported incident) regarding the 5/8/21 altercation between Resident #64 and Resident #297, ASM #1 stated there were no FRIs related to that incident. When asked to provide additional information regarding Resident #64's stay at the facility, ASM #4 stated the psychologist has documented the resident likely has PTSD (post-traumatic stress disorder) (5), bipolar disorder and a mood disorder. She stated the resident is resistant to care and support, that he is independent, and he is able to provide his own care. ASM #4 stated the staff has been working with Resident #64 on medication management and verbal communication rather than aggression. ASM #1 stated the facility attempted to issue the resident a 30-day discharge notice, as the facility staff does not feel like the resident is appropriate for nursing home-level care. She stated Resident #64 appealed the discharge, and his appeal was granted. ASM #1 stated the regulating entity ruled that the facility did not have an acceptable discharge plan for the resident. When asked if Resident #64 has been assessed to be able to leave the facility unsupervised, given his history of falls and seizures, ASM #4 stated: "No, we do not have a form for that." She stated the facility bases the decision to allow Resident #64 to leave the facility unsupervised on his BIMS score (15 out of 15), and that he is his own RP (responsible party). When asked to provide evidence that the facility staff had educated the resident on the risks of leaving the facility unsupervised, given his history of seizures and falls, ASM #4 stated she would have to look. She stated Resident #64 attends appointments with his mother from time to time. ASM #4 stated, "A formalized assessment for his safety does not

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exist in our system." When asked who else is aware that Resident #64 leaves the building unsupervised, she stated the social worker, the administrator, the nursing staff, and the psychologist are aware. When asked where Resident #64 goes when he leaves the building, ASM #4 stated, "I don't know exactly. He is not forthcoming with that information when he leaves." ASM #1 was asked to provide copies of the sign-out sheets for the last six months for Resident #64. She provided a document with six entries, dating from 8/17/21 through 9/14/21. Each entry contained "off prop (property)" in the destination column. ASM #1 stated she was unable to locate any sign-out information prior to August 2021. She added the facility has no evidence to prove what Resident #64 does when he leaves the facility, other than those times he has a scheduled doctor's appointment. ASM #1 stated the smell of alcohol on the resident's breath is not evidence that he has been ingesting alcohol - that it is only a suspicion. She stated when the resident returns and is agitated, "No one can get near him."

On 9/15/21 at 2:21 p.m., ASM #2, the DON (director of nursing) joined the conversation. When asked if he is aware where Resident #64 goes when he leaves the facility unsupervised, ASM #2 stated he does not know for sure. He stated the resident goes out and walks down the street and comes back later. He stated staff have reported that they think they smell alcohol, but that is not definitive. ASM #1 stated Resident #64 avoids staff so no one can physically get close enough for a determination. When asked who is responsible for Resident #64's safety when he leaves the facility unsupervised, ASM #1 stated, "Himself." ASM #2 stated, "He is his own RP."

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When asked what interventions the facility has put in place to provide for Resident #64's safety when he leaves the building unsupervised, there was no answer.

When asked why an FRI was not submitted for the 5/8/21 incident, ASM #1 stated: "It was a resident-to-resident incident. A FRI should have been submitted." When asked to provide evidence of what was done to protect and esnure a safe enviorment for Resident #297 after the incident, ASM #1 stated, "We don't have any." She stated Resident #64 was already on one-to-one supervision for his seizures, but there was no documentation. She stated there was no evidence of assessments for Resident #297, or of updates to either resident's care plan following the incident.

On 9/15/21 at 3:46 p.m., OSM #6, the psychiatry NP, was interviewed. She stated she has not seen Resident #64 since May 2021. When asked why she has not seen Resident #64 since 5/14/21, OSM #6 stated when the resident does not have anything "particular" happening, she does not see him formally. She stated she will sometimes have a conversation in the hallway, but has not had any "billable visits" since 5/14/21. OSM #6 stated Resident #64 refuses all services and medications she offers. When asked if she documented any offers and refusals, she stated she has not. OSM #6 stated the resident leaves the building, and the facility staff has tried to set limits. She stated the resident had an incident in May 2021 that resulted in a contract between the resident and the facility. When asked if she was aware of any occasion, other than the 7/22/21 trip to the emergency room, where the facility attempted to test Resident #64's urine or blood

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for alcohol or drugs, she stated she was not. When asked if Resident #64 is safe to leave the building unsupervised, given his history of falls and seizures, she stated he could be. When asked if other residents are safe when Resident #64 leaves the building unsupervised and comes back altered, OSM #6 stated, "It is totally unsafe for other residents." OSM #6 stated, "It is really difficult to determine his safety." She stated staff has documented that when he returns from his unsupervised time out of the facility, frequently he has dilated pupils and is "clearly altered." OSM #6 stated,"We need to assess him for mental capacity."

On 9/16/21 at 9:21 a.m., OSM #7, the psychologist, was interviewed. When asked about Resident #64, she stated he is sometimes totally alert and oriented, and capable of caring for himself. She stated at other times, he is, in her opinion, under the influence of some type of psychoactive substance. OSM #7 stated, "He turns into a monster." She stated he cannot find his words, and he becomes belligerent and paranoid. When asked if she was aware Resident #64 was leaving the facility unsupervised, she stated she was not aware he was leaving the facility other than with his mother. OSM #7 stated she was not aware the resident had ever suffered a seizure. When asked if other facility residents are safe when he is allowed to leave unsupervised, OSM #7 stated they are not. When asked why she has not seen Resident #64 since 4/8/21, she stated it is because he will not talk to her. She stated the team has offered Resident #64 a medication to treat bipolar disorder, but he has repeatedly refused, as documented multiple times in the clinical record. The facility provided a note from 5/19/21 documenting the resident's

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refusal of the medication to treat bipolar disorder. No further documentation was provided.

On 9/16/21 at 8:02 a.m., 8:55 a.m., 9:16 a.m., and 10:55 a.m., Resident #64 was observed in the day room, accompanied by CNA #7. On 9/16/21 at 9:16 a.m., CNA #7 stated she was assigned to be one on one with Resident #7 for her entire shift that day. A review of the staff schedule for 9/16/21 and 9/17/21 revealed a CNA scheduled to accompany Resident #64 on all shifts.

On 9/16/21 at 9:51 a.m., ASM #1, the administartor, ASM #3, the clinical services specialist, and ASM #4 the clinical services specialist, were informed of these concerns. ASM #3 stated before the team left the facility on 9/15/21, they initiated 15 minute safety checks on Resident #64 for the safety of Resident #64 and for safety of other residents in the facility. ASM #3 stated he had an incident between midnight and 1:00 a.m., making verbal outbursts, cursing, and yelling at other residents and staff. She stated there was suspicion of the smell of alcohol, and the resident repeatedly went out into the courtyard and came back in. ASM #1 stated the staff searched his room and the courtyard, but found nothing unusual. She stated the resident was put on one-to-one supervision. ASM #1 stated they called OSM #7 to come in that morning, and before she arrived, Resident #64 became violent toward a staff member. ASM #1 stated she has called the local police, the ombudsman, and the local community services board. She stated the local community services board has refused to come to the facility to assess the resident because he is already in a medical facility, on one-to-one supervision. ASM

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#1 stated the facility is initiating a five day discharge notice to Resident #64. She stated as of that morning, Resident #64 is no longer allowed to leave the facility unsupervised. ASM #4 stated the other residents are safe from Resident #64 now that he is on one-to-one supervision, and is not allowed to leave the facility unsupervised. ASM #1 stated the facility does not have any documentation regarding an assessment of Resident #297 for the 5/8/21 incident. She stated she should have been assessed, and interventions should have been put in place and added to the care plan. When asked to provide evidence that the facility attempted to test Resident #64's urine and blood for foreign substances, per the resident's agreement with the facility, following any of the documented occasions where he showed evidence of having consumed alcohol or was altered in any way, ASM #1 stated there was no evidence. She referred back to the 7/22/21, emergency room screening that was performed when the resident was diagnosed with the fractured clavicle. ASM #1 stated she could not provide any evidence that Resident #64 had been educated regarding the risks of leaving the facility unsupervised, given his history of seizures and falls.

A review of the facility policy, "Accidents and Supervision," revealed, in part: "Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: Identifying hazards and risks. Evaluating and analyzing hazards and risks. Implementing interventions to reduce hazards and risks. Monitoring for effectiveness and modifying interventions when necessary...The facility should make a reasonable effort to identify the hazards

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and risk factors for each resident...Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk...Development of interim safety measures may be necessary if interventions cannot immediately be implemented fully..Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents."

No further information was provided prior to exit.

REFERENCES
(1) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) "The epilepsies are a spectrum of brain disorders ranging from severe, life-threatening and disabling, to ones that are much more benign. In epilepsy, the normal pattern of neuronal activity becomes disturbed, causing strange sensations, emotions, and behavior or sometimes convulsions, muscle spasms, and loss of consciousness." This information is taken from the website https://www.ninds.nih.gov/Disorders/All-Disorders/Epilepsy-Information-Page.

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(3) "COPD, or chronic obstructive pulmonary disease, is a progressive disease that makes it hard to breathe. Progressive means the disease gets worse over time. COPD can cause coughing that produces large amounts of a slimy substance called mucus, wheezing, shortness of breath, chest tightness, and other symptoms." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/copd.

(4) "Topiramate is used alone or with other medications to treat certain types of seizures including primary generalized tonic-clonic seizures (formerly known as a grand mal seizure; seizure that involves the entire body) and partial onset seizures (seizures that involve only one part of the brain). Topiramate is also used with other medications to control seizures in people who have Lennox-Gastaut syndrome (a disorder that causes seizures and developmental delays). Topiramate is also used to prevent migraine headaches but not to relieve the pain of migraine headaches when they occur. Topiramate is in a class of medications called anticonvulsants. It works by decreasing abnormal excitement in the brain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a697012.html.

(5) "Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event...Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger." This information is taken from the website https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.

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2. The facility staff failed to wrap Resident # 35's right and left bedrails with a towel for seizure precautions according to the physician's orders.

Resident # 35 was admitted to the facility with the diagnoses that included but were not limited to: epilepsy [1]. Resident # 35's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 07/10/2021, coded Resident # 35 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions.

On 09/14/21 at 4:25 p.m., an observation of Resident # 35 revealed the resident lying in bed with the upper right and left bedrails raised. Further observation failed to evidence the bedrails covered/padded with a towel.

On 09/15/21 at 10:30 a.m., an observation of Resident # 35 revealed the resident lying in bed with the upper right and left bedrails raised. Further observation failed to evidence the bedrails covered/ padded with a towel.

The physician's orders for Resident # 35 documented in part, "Wrap both right and left side rails with towels for seizure precaution. Every shift for h/o [history of] seizure. Order date 9/17/21."

The comprehensive care plan for Resident # 35 dated 07/04/2021 failed to evidence a care plan to address Resident # 35's diagnosis of epilepsy.

On 09/16/21 at 11:33 a.m., an observation of

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F 689	Continued From page 69 Resident # 35's room and interview was conducted with LPN [licensed practical nurse] # 4. Upon entering Resident # 35's bedroom LPN # 4 was asked to observed Resident # 35's bedrails. When asked if the bedrails were wrapped in a towel, LPN # 4 stated no. When asked to describe the position of Resident # 35, LPN # 4 stated that she was lying in bed. When asked about the physician's order for Resident # 35's bedrails to be wrapped in a towel, LPN # 4 stated that they were aware of the order. On 09/16/2021 at approximately 3:35 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, director of operations and ASM # 4, clinical service specialist, were made aware of the above findings. No further information was provided prior to exit. References: [1] A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.	F 689		
F 697 SS=E	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,	F 697		10/26/21

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F 697	Continued From page 70 the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to have a complete pain management program for two of 31 residents in the survey sample, Resident #32 and Resident #63. 1. The facility staff failed to offer non-pharmacological interventions prior to the administration of an as needed pain medication and failed to document the location of Resident #32's pain. 2. The facility staff failed to document the location of Resident #63's pain on multiple occasions in September 2021 when administering an as-needed pain medication to him. The findings include: 1. Resident #32 was admitted to the facility on 5/29/2021 with a recent readmission on 6/22/2021, with diagnoses that included but were not limited to: pneumonia (1), depression, asthma (2), and a pressure injury on the sacral area (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/9/2021, coded Resident #32 as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of her activities of daily living. Resident #32	F 697	1.It is noted that facility staff failed to complete a pain management program for residents #32 and 63. Residents #32 licensed nurses re-educated on utilizing non-pharmacological intervention prior to administration of pain medication no untoward effects to resident. Resident #63 medical record was updated to included location of pain on 10-8-21. 2.Any resident who resides in the center could be affected if a pain management program is not initiated. Review of patients that have received pain medication in the last 14 days will be reviewed to ensure appropriate documentation any variances will be corrected. 3.The Don or designee will educate Licensed nursing staff on pain management program policy. 4.DON or designee will audit pain management 5x a week for 4 weeks, weekly for 4 weeks, and once monthly. DON to report findings to QAPI committee. 5.Compliance date is 10/26/21.	

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was coded as requiring supervision after set up assistance was provided for eating. In Section J - Health Conditions, the resident was coded as receiving as needed pain medications for occasional pain.

The physician orders dated, 6/21/2021, documented, "Tylenol Tablet 325 mg (milligram) (Acetaminophen) (used to treat mild to moderate pain) (4) Give 2 tablet by mouth every 4 hours as needed for pain."

The August 2021 MAR (medication administration record) for Resident #32 documented the above physicians order for Tylenol and documented the Tylenol was administered on the following dates and times for the following documented pain levels:
8/18/2021 at 5:20 a.m., and 8/20/2021 at 5:50 a.m. - for pain levels of "5."
8/20/2021 at 9:10 p.m. - pain level of "7."
8/25/2021 at 5:25 a.m., 8/26/2021 at 6:20 a.m., and 8/28/2021 at 12:30 a.m. - pain levels of "5."
8/29/2021 at 1:45 p.m. - pain level of "6."

Review of the nurses noted for the dates above revealed the following documentation:
8/18/2021 at 5:20 a.m. documented, "Resident c/o (complained of) pain to lower abdomen, resident denies spastic pain. Pain level 5/10 (five out of a pain scale of 0 -10, ten being the worse pain ever in and zero meaning no pain)." There was no documentation of non-pharmacological interventions provided or offered.
8/20/2021 at 5:50 a.m. documented, "Resident c/o minor body aches, afebrile, and encouraged to drink fluids. Pain level 5/10." There was no documentation of non-pharmacological interventions provided or offered.

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8/20/2021 at 9:10 p.m. documented, "Tylenol 2 tabs (tablets) for headache, pain level of 7/10." There was no documentation of non-pharmacological interventions provided or offered.
8/25/2021 at 5:25 a.m. documented, "Resident c/o pain to sacrum. Pain level 5/10." There was no documentation of non-pharmacological interventions provided or offered.
8/26/2021 at 6:20 a.m., and 8/28/2021 at 12:30 a.m., both entries documented, "Resident c/o pain to sacrum, pain level 5/10."
8/29/2021 at 1:45 p.m. failed to document the location of the pain or non-pharmacological interventions offered.

The September 2021 MAR for Resident #32 documented the above physicians order for Tylenol and documented the Tylenol was administered on the following dates and times for the following documented pain levels:
9/2/2021 at 12:24 p.m. and 9/3/2021 at 9:31 a.m. - pain levels of "6."
9/4/2021 at 9:28 p.m. and 9/14/2021 at 12:16 p.m. - pain levels of "5."
9/6/2021 at 12:08 p.m., 9/7/2021 at 8:26 a.m., 9/10/2021 at 1:41 p.m., and 9/12/2021 at 8:20 p.m. - pain levels of "6."

Review of the nurse's notes for the dates above revealed the following:
9/2/2021 at 12:24 p.m., 9/3/2021 at 9:31 a.m., 9/4/2021 at 9:28 p.m.,9/6/2021 at 12:08 p.m.,9/10/2021 at 1:41 p.m., 9/7/2021 at 8:26 a.m., 9/12/2021 at 8:20 p.m., all failed to evidence documentation of the location of the pain and if non-pharmacological interventions were attempted or offered. The nurse's note

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dated, 9/14/2021 at 12:16 p.m. documented, "Resident complained of pain to right knee. On the pain scale of 1 -10, she stated it is a 5/10." There was no documentation if non-pharmacological interventions were offered.

The comprehensive care plan dated, 6/22/2021, documented, "Focus: (Resident #32) has pain or potential for pain." The "Interventions" documented, "Administer pain medications as ordered. Report s/s (signs and symptoms) potential negative side effects. Assess pain level q (every) shift and PRN (as needed) and apply interventions as needed. Assist with alternate positioning and other diversional activities to relieve pain."

An interview was conducted with LPN (licensed practical nurse) #1 on 9/16/2021 at 10:30 a.m. LPN #1 administered the Tylenol in September on several occasions. When asked about the process staff follows for resident complaints of pain, LPN #1 stated. "She first asks the resident to rate the pain level, where it is, and what makes it better or worse." LPN #1 stated, "she then tries a distraction, ice or hot compress, if that doesn't work, I look at the orders to give them pain medications." When asked where the distractions, location of pain and the pain scale rating is documented, LPN #1 stated it's on the computer as soon as you pull up the pain medication. When shown the some of the above times and dates when she administered the Tylenol, LPN #1 stated she failed to document a note under the section in the medication administration record that's on the pain medication screen.

An interview was conducted with ASM

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(administration staff member) #2, the director of nursing, on 9/16/2021 at 11:41 a.m. When asked the process for giving an as needed pain medication, ASM #2 stated the nurse should document that it was given, the location of the pain, the level of pain, any non-pharmacological interventions provided and a follow up to determine if it was effective. When asked where it was documented, ASM #2 stated in a nurse's note.

The facility policy, "Pain Management" documented in part, "Policy: 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 resident's goals and preferences....Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (nurse, practitioners, pharmacists, and anyone else with direct contact with the resident) may necessitate gathering the following information as applicable to the resident: History of pain, asking the patient to rate the intensity of his/her pain using a numerical scale, a verbal or visual description that is appropriate and referred by the resident, Reviewing the resident's current medical conditions, identifying key characteristic of the pain, obtaining descriptors of the pain, identifying activities, resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain, current prescribed pain medications, dosage and frequency.....Non-pharmacological interventions will include but are not limited to: environmental comfort measures, loosening any constrictive bandage, clothing or device, applying splinting,

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physical modalities such as cold compress, warm shower/bath, exercised to address stiffness and prevent contractures, cognitive/behavioral interventions...Facility staff will reassess resident's pain management for effectiveness and/or adverse consequences."

ASM #1, the administrator, ASM #2, the director of nursing, ASM # 4, the clinical services specialist and ASM #3, the director of operations, were made aware of the above concern on 9/16/2021 at 3:33 p.m.

No further information was provided prior to exit.

References:
(1) Pneumonia: An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. This information was obtained from the following website: https://medlineplus.gov/pneumonia.html.

(2) Asthma: respiratory disorder characterized by recurrent episodes of difficulty in breathing, wheezing, cough, and thick mucus production, caused by inflammation of the bronchi. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 51.

(3) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition,

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perfusion, co-morbidities and condition of the soft tissue. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

(4) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html

2. The facility staff failed to assess/document the location of Resident #63's pain on multiple occasions in September 2021 when administering an as-needed pain medication to the resident.

Resident #63 was admitted to the facility on 4/5/21, and was most recently readmitted on 5/17/21, with diagnoses including congestive heart failure (1), diabetes (2), and bipolar disorder (3). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/2/21, Resident #63 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as frequently experiencing pain, and as having received an opioid pain medication on three days of the look back period.

A review of Resident #63's clinical record revealed the following physician order: "Oxycodone HCl [hydrochloride] (4) Tablet 5 MG (milligrams). Give 1 tablet by mouth every 6 hours as needed for pain. Start Date 05/18/2021."

A review of Resident #63's MARs (medication administration records) for September 2021 revealed that he received Oxycodone 5 mg by

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mouth on the following dates and times: 9/3/21 at 8:00 a.m., 9/6/21 at 8:03 a.m., 9/7/21 at 11:03 a.m., 9/8/21 at 7:58 a.m., and 9/9/21 at 8:00 a.m. Further review of Resident #63's MARs and progress notes revealed no documentation of the location of Resident #63's pain for any of these administrations.

A review of Resident #63's comprehensive care plan, dated 4/26/21 and revised 7/16/21, revealed, in part: "[Resident #63] has pain or potential for pain...Administer pain medication as ordered."

On 9/16/21 at 10:31 a.m., LPN (licensed practical nurse) #1 was interviewed, regarding the process staff follows when administering an as needed pain medication to a resident. LPN #1 stated she asks the resident to rate the pain, describe the location, and to tell her if anything makes the pain better or worse. She stated these items should all be documented in the nurse's note.

On 9/16/21 at 11:41 a.m., ASM #2 was interviewed. When asked what documentation should accompany the administration of an as needed pain medication to a resident, he stated the nurse should document that the medication was actually given, the location of the pain, the pain level, non-pharmacological interventions attempted, and a follow-up to document whether the medication was effective.

On 9/16/21 at 9:51 a.m., ASM (administrative staff member) #1, the administrator, ASM #3, the director of operations, and ASM #4, the clinical services specialist, were informed of these concerns.

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F 697	Continued From page 78 No further information was provided prior to exit. (1) "Heart failure is a condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body...As the heart's pumping becomes less effective, blood may back up in other areas of the body. Fluid may build up in the lungs, liver, gastrointestinal tract, and the arms and legs. This is called congestive heart failure." This information is taken from the website https://medlineplus.gov/ency/article/000158.htm (2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (3) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. (4) "Oxycodone is used to relieve moderate to severe pain... Oxycodone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682132.html.	F 697		
F 698 SS=E	Dialysis CFR(s): 483.25(l)	F 698		10/26/21

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F 698	Continued From page 79 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and service for a complete dialysis [1] program for two of 31 residents in the survey sample, Residents # 10 and Resident #33. The facility staff failed to ensure ongoing communication regarding Resident #10 and Resident #33's care with the residents' dialysis centers. The findings include: 1. Resident # 10 was admitted to the facility with diagnoses included but were not limited to: end stage kidney disease [2]. Resident # 10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/13/2021, coded Resident # 10 as scoring a three [3] on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 10 for "Dialysis" while a resident. The POS [physician's order sheet] for Resident # 10 documented, "Resident receives dialysis as follows: in the afternoon every MON [Monday],	F 698	1. It is noted that facility staff failed to provide care and services for a complete dialysis program for residents #10 and 33. Resident #10 and # 33 Dialysis books updated to include center information. 2. Any resident who resides at the facility could be affected if the facility fails to provide a complete dialysis program and ensure there is effective communication between facilities. 100% audit of all residents who receive dialysis will be audited to ensure the center has implemented a dialysis program for these patients. 3. The Don or designee will educate licensed nurses on dialysis policy. 4. DON or designee will audit dialysis patients to ensure dialysis program and dialysis communication books are current and up to date 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 5. Compliance date 10/26/21	

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Wed [Wednesday], Fri [Friday] for Dialysis. Start Date: 2/3/2021."

The comprehensive care plan for Resident #10's dated 10/17/2020 documented in part, "Focus: Has Renal Disease requiring dialysis 3x/week [three times per week], at times refusing to go. Date Initiated: 10/17/2020." Under "Interventions" it documented in part, "Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via [by] pre/post [before/after] treatment notes. Date Initiated: 10/17/2020."

Review of facility's nurse's notes dated 08/01/2021 through 09/15/2021 for Resident # 10 failed to evidence documentation that the facility staff provided ongoing communication regarding Resident # 10 to the dialysis center staff.

Review of Resident #10's dialysis communication book contained dialysis communication forms from 08/04/2021 through 09/15/2021 that documented headings for "Date, Weight Pre, Weight Post, Labs [laboratory], Changes in Condition, Changes in Medication, Diet to Center, Nutrition % [percentage] Taken, Signature." Further review of the dialysis communication sheets failed to evidence documentation regarding Resident # 10's fluid restrictions, advance directive, blood pressure, pulse, respiration, temperature or medication.

On 09/16/21 at 11:25 a.m., an interview was conducted with LPN [licensed practical nurse] # 3. After LPN #3 reviewed Resident # 10's dialysis communication book, LPN # 3 was asked what information was documented by the facility to the dialysis center on the days of Resident # 10's

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appointments to the center. LPN # 3 stated, "We send the date and his weight when he leaves, we don't send any other vitals. Dialysis fills in the post weight, change in condition and change in medication sections."

On 09/16/21 at 12:00 p.m., an interview was conducted with ASM [administrative staff member] # 2, director of nursing, regarding Resident # 10's dialysis communication book. When asked to describe what resident information the facility needed to send at each visit to the dialysis center ASM # 2 stated, "The medication list, face sheet and labs, if any are done and vital signs that include blood pressure, pulse, respiration." After ASM #2 reviewed Resident # 10's dialysis communication sheets dated 08/04/2021 through 09/15/2021, ASM # 2 stated, "It's not conducive to the information that needs to be sent."

The facility's policy " Hemodialysis" documented in part, "Compliance Guidelines: 4. The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: a. Timely medication administration (initiated, held or discontinued) by the nursing home and/or dialysis facility; b. Physician/treatment orders, laboratory values, and vital signs; c. Advance Directives and code status; specific directives about treatment choices; and any changes or need for further discussion with the resident/representative, and practitioners; d. Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output

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measurements as necessary. e. Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments; f. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site. G. Changes and/or declines in condition unrelated to dialysis. h. The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility."

On 09/16/2021 at approximately 3:35 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, director of operations and ASM # 4, clinical service specialist, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.

[2] The last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.
2. The facility staff failed to ensure ongoing

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communication with dialysis center for Resident #33.

Resident #33 was admitted to the facility on 12/16/20, and most recently readmitted on 1/17/21, with diagnoses including ESRD (end stage renal disease) (1), diabetes (2), and CHF (congestive heart failure) (3).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 7/5/21, Resident #33 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as having received dialysis during the look back period.

A review of Resident #33's physician orders revealed the following order: "Resident receives Dialysis as follows: Dialysis Center: [name and location of dialysis center]...Dialysis Days: M-W-F (Monday/WednesdayFriday; Chairtime: 14:15PM; Dialysis Medical DX (diagnosis): Acute Renal Disease. 6/18/21."

A review of Resident #33's dialysis communication sheets for August and September 2021revealed columns for the date, pre- and post-dialysis weights, vital signs/laboratory tests performed, changes in condition, changes in medication, diet, amount taken in, and a signature. The sheets contained no space for the facility to record and send any information regarding Resident #33's condition to the dialysis center.

A review of Resident #33's comprehensive care plan dated 3/27/21 revealed, in part: "[Resident

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#33] has renal disease requiring dialysis...Encourage to adhere to fluid restrictions as recommended or ordered...Coordinate with Dialysis center for dialysis treatments as ordered. Communicate with dialysis provider regularly via pre/post treatment notes."

On 09/16/21 at 11:25 a.m., an interview was conducted with LPN (licensed practical nurse) #3. After reviewing Resident #3's dialysis communication sheets, LPN #3 was asked what information was documented by the facility to the dialysis center. LPN #3 stated, "We send the date and his weight when he leaves, we don't send any other vitals. Dialysis fills in the post weight, change in condition and change in medication sections."

On 09/16/21 at 12:00 p.m., an interview was conducted with ASM#2 regarding facility communication with the dialysis center. When asked to describe what resident information the facility needed to send at each visit to the dialysis center ASM #2 stated, "The medication list, face sheet and labs, if any are done and vital signs that include blood pressure, pulse, respiration." After reviewing Resident #33's dialysis communication sheet for September 2021, ASM # 2 stated, "It's not conducive to the information that needs to be sent."

On 9/16/21 at 3:33 p.m., ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the director of operations, and ASM #4, the clinical services specialist, were informed of these concerns.

No further information was provided prior to exit.

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F 698	Continued From page 85 (1) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website https://medlineplus.gov/ency/article/000500.htm. (2) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (3) "Heart failure is a condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body...As the heart's pumping becomes less effective, blood may back up in other areas of the body. Fluid may build up in the lungs, liver, gastrointestinal tract, and the arms and legs. This is called congestive heart failure." This information is taken from the website https://medlineplus.gov/ency/article/000158.htm	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726		10/26/21

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F 726	Continued From page 86 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure that two of five CNA [certified nursing assistant] records reviewed had received required annual competencies, CNA #1 and #2. The facility failed to evidence completed competencies for CNA [certified nursing assistants] # 1 with a hire date of 06/26/2018 and CNA # 2 with a hire date of 05/16/2017. The findings include: Upon entrance on 09/14/21 at approximately 11:00 a.m., an Entrance Conference form was provided to ASM [administrative staff member] # 1, administrator. One document on this form was a request for a list of all current CNA [certified	F 726	1. It is noted that facility staff failed to ensure that CNA #1 and CNA #2 records did not have annual competencies. CNA #1 and CAN #2 competencies update on 10/1/21 2. Any resident who resides at the center could be affected if employee records are not accurately completed. 3. The Don or Designee will educate c.n.a□s on completing annual competencies. 4. Human Resources or designee will audit all employee files. 5. Compliance date is 10/26/21.	

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nursing assistant] staff who had been employed at the facility for longer than one year. The list provided contained seven CNA's that had been employed longer than a year and was still employed at the facility. A request was made for both CNA #1 and CNA #2's annual training and competency evaluations.

On 09/16/21 at 9:56 a.m., during a meeting with ASM # 1, ASM # 2 and ASM # 3, a concern was expressed regarding the competencies for CNA [certified nursing assistants] # 1 with a hire date of 06/26/2018 and CNA # 2 with a hire date of 05/16/2017. ASM [administrative staff member] # 1, administrator, stated that they did not have the competencies for CNA # 1 and CNA # 2.

The facility's policy "Competency Policy" documented in part, "PROCEDURE: 1. Center Level Competency Responsibilities: a. The competency checklist must be completed by the mentor, supervisor, or department manager of each position of existing associates in each position through direct observation of each specific competency. An education needs assessment should be completed to determine the additional education, if any, each associate needs to improve or meet competency levels. b. Centers will incorporate use of the competencies into orientation of each position. c. Centers will complete competencies for all new hires or rehires within the associates first 90 days of employment. Competencies will be maintained in the associates personnel file by the Center's Human Resources Generalist. d. Centers will complete an annual competency review for each position as part of the associates annual performance evaluation."

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F 726	Continued From page 88 On 09/16/2021 at approximately 3:35 p.m., ASM [administrative staff member] # 1, administrator, ASM # 2, director of nursing, ASM # 3, director of operations and ASM # 4, clinical service specialist, were made aware of the above findings. No further information was provided prior to exit.	F 726		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		10/26/21

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F 732	Continued From page 89 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to post daily nurse staffing information on 09/14/2021 and 09/15/2021. On 9/14/21 the staff posting in the front lobby was dated "August 23, 2021" and on 9/15/21 the staff posting in the front lobby was dated 9/14/21. The findings include: On 09/14/2021 at 11:25 a.m., an observation conducted on the facility's Clairmont and Fairview units failed to evidence the nurse staff information. At 11:35 a.m., an observation of the facility's lobby revealed a staff posting dated "August 23, 2021." On 09/15/21 at 10:15 a.m., an observation conducted on the facility's Clairmont and Fairview units failed to evidence the daily nurse staffing information. At 10:20 a.m., an observation of the facility's lobby revealed a staff posting dated "August 14, 2021." On 09/15/21 at 2:41 p.m., an interview was conducted with CNA [certified nursing assistant] # 3, staffing coordinator. When asked about the	F 732	1. It is noted that facility staff failed to post daily nurse staffing information. Nurse staffing information has been updated. The facility staff posting was corrected on 9/16/21 2. Any resident who resides at the facility could be affected if facility staff fails to post staffing data. The facility will complete a 30day review of staff posting any variances will be corrected. 3. The DON or designee will educate the staffing coordinator , nursing supervisor and receptionist on daily posting of staff information. 4. DON or designee will audit daily staffing data 5x a week for 4 weeks and monthly x2. 5. Compliance date is 10/26/2021.	

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F 732	Continued From page 90 posting of the daily nurse staffing CNA # 3 stated that it is posted in the lobby and on the wall on each unit. When informed of the above findings, CNA # 3 agreed with the findings. When asked about the process for putting the nurse posting out CNA # 3 stated that it is posted between 7:30 a.m. and 8:00 a.m. each morning. The facility's policy "Nurse Staffing Posting Information" documented in part, "Policy Explanation and Compliance Guidelines: 1. The Daily Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name, b. The current date, c. Facility's current resident census, d. The total number and the actual hours worked by the following categories of licensed and unlicensed staff directly responsible for resident care per shift: i. Registered Nurses, ii. Licensed Practical Nurses/Licensed Vocational Nurses, iii. Certified Nurse Aides. 2. The facility will post the Daily Staffing Sheet at the beginning of each shift. 3. The information posted will be: a. Presented in a clear and readable format. b. In a prominent place readily accessible to residents and visitors. 4. A copy of the schedule will be available to all supervisors to ensure the information posted is up-to-date and current. On 09/16/2021 at approximately 9:56 a.m., ASM [administrative staff member] # 1, administrator, ASM # 3, director of operations and ASM # 4, clinical service specialist, were made aware of the above findings. No further information was provided prior to exit.	F 732		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40	F 740		10/26/21

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F 740	Continued From page 91 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide behavioral health services for one of 31 residents in the survey sample, Resident #64. The facility staff failed to evidence that behavioral health services were offered to Resident #64 between 5/14/21 and 8/15/21. The findings include: Resident #64 was admitted to the facility on 7/25/18 with diagnoses including a femur fracture, bipolar disorder (1), epilepsy (2), alcohol abuse, and nicotine dependence. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/3/21, Resident #64 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). He was coded as having demonstrated no mood disorder symptoms, no psychosis, no behaviors toward himself or others, no rejection of care, and no wandering. He was coded as being independent	F 740	1. It is noted that facility staff failed to provide behavioral health services for resident #64. Resident #64 behavioral services reviewed and corrected seen by psych service date 9/16/21 2. Any resident who resides at the facility could be affected if the facility fails to provide behavioral health services. A 14 day review of resident who exhibited behaviors will be audited to ensure behavior health services have occurred any variances will be corrected. 3. The Don or designee will educate licensed nurses, and social services on providing behavioral health services. 4. DON or designee will audit behavioral health services 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 5. Compliance date is 10/26/21.	

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in all ADLs (activities of daily living), as having no functional limitations with range of motion in upper or lower extremities, and as always continent of both bladder and bowel. He was coded as using a wheelchair for locomotion during the look back period.

On 9/15/21 at 8:30 a.m., Resident #64 was observed standing in the hallway near the nurses' desk. He walked from the nurses' desk through the day room, and stepped out into the courtyard.

On 9/15/21 at 11:22 p.m., Resident #64 was observed sitting in the day room in a wheelchair.

A review of Resident #64's clinical record revealed the following progress notes:

"5/8/2021 12:31 (12:31 p.m.) *Behavior Note Behavior Observed (Onset and Duration): Resident walked out of the facility in the morning without using wheel-chair, he came back with signs of being intoxicated. At around 1030 (10:30 a.m.), resident noted with extreme agitation, tried to hit staff and the writer. Writer tried to calm resident down and redirect him, but resident was not cooperative, writer called 911 for help. Police officer stayed with resident for about 45 minutes and recommended writer to call family and MD (medical doctor) for a quick discharge, because of safety concerns of the staff and other employees. Police officers told writer that resident stated: 'I don't want to be here.' Family and MD notified."

"5/8/2021 13:09 (1:09 p.m.) Social Services Note Late Entry: Note Text: 05/08/2021, at approximately 9:30 p.m. [local police department]

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arrived to serve ECO (emergency custody order) which was approved by magistrate. Resident completed a virtual evaluation with [local CSB (community services board) Representative with [local police department] present."

"05/08/2021 at approximately 9:50 p.m. SS Care Coordinator (SSCC) spoke with [name CSB representative]. SSCC provided [CSB representative] with a hx (history) of Resident's behavior and actions on 05/08/2021 along with a hx of his medical condition, mental illness, and suspected substance abuse. [CSB representative] shared that during the evaluation, Resident denied having a mental illness dx (diagnosis) and denied substance abuse. [CSB representative] shared that she would have her Supervisor review her evaluation and give SSCC a call back.
05/08/2021 at approximately 11 p.m. SSCC received phone call from [CSB representative]. She shared that her Supervisor determined that Resident does not meet ECO criteria."

5/8/2021 16:14 (4:14 p.m.) *Behavior Note Behavior Observed (Onset and Duration): Cna (certified nursing assistant) reported to writer that she observed resident slamming his wheelchair into the same resident [Resident #297] wheelchair multiple times. Cna also stated resident had enough room to pass around the resident without slamming the wheelchair."

"5/8/2021 18:32 (6:32 p.m.) Social Services Note Text: 05/08/2021, 5:15 p.m. SS [social services] Care Coordinator met with magistrate at Prince William County Adult Detention Center in Manassas, VA. SSCC submitted a petition for ECO (Emergency Custody Order) for Resident,

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[name of Resident #64] due to his attempt to physically harm staff members and other elderly residents at the center on the morning of 05/08/2021. Center awaits magistrate's decision to deny or grant the ECO."

"05/08/2021, 6:15 p.m. SS [social services] CC arrived at the center to assess the situation in regard to Resident's behavior. Resident prompted conversation with SSCC. Resident was noted to have dilated pupils, unable to finish his thoughts, repeating himself often, and easily distracted. Resident rambled on about the events that occurred earlier in the day; however, Resident's thoughts remained scattered. Staff will continue to monitor Resident closely due his unpredictable and abrasive/threatening behavior and demeanor."

"5/14/2021 11:30 (11:30 a.m.) Social Services Note Late Entry: Note Text: IDT (interdisciplinary team) conducted Care Plan Meeting with Resident to discuss behavior management. IDT Members present for meeting include: Administrator, DON (director of nursing), ADON (assistant director of nursing), SS (social services) Care Coordinator, Psych (psychiatry) NP (nurse practitioner), and Psychologist. Resident denied being verbally or physically aggressive toward staff or other residents on 05/08/2021. When asked why the police were called on this date, Resident stated it was because he and ADON do not get along; then he changed the subject. Resident denied consuming alcohol and denied using any other substances. When asked why his behavior and overall demeanor are significantly different after he returns from LOA, Resident could not provide an answer. When asked why he smells of alcohol

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and has increase in falls after returning from LOA, Resident could not provide an answer.
At the conclusion of the meeting, Resident agreed to the following:
-Allowing staff to search his room and personal belongings at any time as long as he is present.
-Providing blood or urine for toxin screen to be completed.
-Going on LOA only during Monday through Friday between the hours of 8 a.m. to 4 p.m."

"8/2/2021 16:52 (4:52 p.m.) Health Status Note Text: Resident face is red, flashed when he was passing me by. i (sic) smelled alcohol from him. Morning nurse gave me report that earlier in the morning he was out."

"8/2/2021 20:43 (8:43 p.m.) Health Status Note Text: At 18.50 (6:50) pm resident was cursing calling me 'Bitch' he would come into nursing station, aggressive and yelling, supervisor asked him to leave area, he got up from his wheelchair and started going onto him, repeating 'What's you gonna do' threatening him. So supervisor told me to call 911. When later at 19.15 policemen came they talked to me, to resident and supervisor."

Further review of Resident #64's progress notes revealed the following notes from psychology/psychiatric services providers:

"3/26/2021 12:19 (12:19 p.m.) Psych (psychology) Note Late Entry: Note Text: Psychiatric Progress Note Chief Complaint: Patient seen to evaluate mental status and adjust medications for behavioral disturbance.
History of Present Illness
Pt was seen on 3/26/2021 for recent impairment in mood and behavior. Staff reported he was

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agitated with staff last night and cut his IV line while he was receiving IV antibiotics treatment to go out and smoke. He was uncooperative with the care provided. He is seen sitting in the W/C (wheelchair) in the hallway, he is alert, not in any distress, flat affect, reported doing ok "when I have issues I directly go to DON [director of nursing] and ADON [assistant director of nursing]", the patient got irritable when asked about the incident that happened last night, he got agitated and noted to have a frequent mood swing, using inappropriate words to describe staffs and facility, "I wish the situation triggers me for seizure, that is what I am waiting on". Seems like he is doing everything intentionally. He reported having a fair appetite and sleep. Denied depression, hallucination, paranoia, and psychosis. Chart and medication reviewed.
Psychiatric Hospitalization, Bipolar disorder
According to his mother, the patient previously saw a psychiatrist...Pt (patient) has Hx (history) of ETOH (alcohol) abuse and may possibly be buying ETOH. Discussed risks of using ETOH with pt...Behavior: Agitated, Intrusive. Speech: Hyperverbal. Gait: Wheel Chair but walks, says uses w/c [wheel chair] d/t seizure concerns.
Mood: Irritable
Affect: Labile, Irritable
Thought process: Circumstantial
Thought Content: No hallucinations, Grandiose delusions
Suicidality: None/denies
Homicidality: None/denies
Insight/Judgement: Poor
Diagnosis Substance Induced Mood Disorder -
Bipolar Disorder ' Mixed ' Unspecified -
Disorder Secondary to Medical Conditions -
Alcohol abuse uncomplicated-
Nicotine Dependence unspecified

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Treatment Plan / Recommendations Plan: Supportive therapy provided...Psychiatric team will monitor mood and behavior, Performance measures
Will continue to monitor his mood and behavior
1:1 Supportive therapy, Insight-oriented Psychotherapy, Relaxation Techniques, Encouragement, Discussed
strategies to maintain mood stability, Progress/collaboration discussed with nursing staff." This note was signed by OSM (other staff member) #7, the psychologist.

"4/8/2021 18:02 (6:02 p.m.) Psych Note Text: PsychoGeriatric Services, LLC.
E-signed by [OSM #7]. on 04/08/2021 3:19PM EDT
Psychotherapy Progress Note :
Treatment provided: Psychotherapy follow up (40-50 minutes)
Follow-up for: Adjustment, Bipolar disorder
Goals Addressed: Other: Patient concerns
Patient's Concerns/Focus: Patient requested meeting with this provider today; he has his face sheet and wanted a detailed explanation of all of his diagnoses; validated feelings...explained psych [psychiatric] dx (diagnosis); patient satisfied with this explanation
Suicidality: None
Homicidality: None
Mental Status Exam:
oriented times three, able to recall date of birth and capital of Us
Interventions Used: Coordination of care with other PGS clinicians, 1:1 Supportive therapy
Plan: Monitor Psychological Symptoms
Progress Toward Goal(s): Treatment Beginning
Follow up visit: Not needed Patient will be seen PRN

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Diagnosis:
Bipolar Disorder ' Manic without Psychotic Features ' Unspecified - F31.10
Chief Complaint: adjustment."

5/14/2021 13:26 (1:26 p.m.) Psych Note Late Entry: Note Text: Psychiatric Progress Note
Chief Complaint: Patient seen to evaluate mental status and adjust medications for behavioral disturbance
Chief Complaint Comments: Care plan meeting with the patient relating his escalated behavior issues
History of Present Illness
[Resident #64] is seen on 5/14/2021 for care plan meeting regarding patient escalated behavior issues recently.
The meeting was held in conference room with the patient in presence of this provider, psychologist, SW (social service care coordinator), DON, ADON, and facility administrator. The patient has shown behavior concern especially in the weekend for past couple of weeks. Per staff notes he goes out of the facility and when he comes back to the facility "Resident was noted to have dilated pupils, unable to finish his thoughts, repeating himself often, and easily distracted". Reported he has agitated behavior towards the staff and other resident in the facility. Patient denied being intoxicated with any alcohol or substance abuse while he is in the facility. Upon
asking about cause of his agitation he talks about random things and avoided conversation focused on alcohol intake or substance use (patient has a history of alcohol abuse, crystal meth and cocaine use). He is noted to be defensive for any questions asked and had a perseverative thoughts. Per staffs he has been

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refusing medical services including outpatient referrals and lab [laboratory] works. At the end of the meeting patient agreed to comply with the purposed facility protocol, and agreed with lab works. No overt symptoms suggestive of depression, SI/HI [suicidal ideation/homicidal ideation], and hallucination noted. He reported having a fair appetite and sleep at night. Chart and medication reviewed.
Pt has Hx of ETOH abuse and may possibly be buying ETOH. Discussed risks of using ETOH with pt.
Mental Status Exam
Attitude: Defensive, Guarded
Appearance: Appropriate, Thin Habitus
Behavior: Intrusive
Speech: Hyperverbal
Gait: Wheel Chair but walks, says uses w/c d/t [wheelchair/due/to] seizure concerns
Mood: Irritable
Affect: Labile
Thought process: Circumstantial
Thought Content: No hallucinations, Grandiose delusions
Suicidality: None/denies
Homicidality: None/denies
Insight/Judgement: Poor
Diagnosis Substance Induced Mood Disorder - F19.94 Bipolar Disorder ' Mixed ' Unspecified - F31.6 Anxiety
Disorder Secondary to Medical Conditions - F06.4
Alcohol abuse uncomplicated- F10.10
Nicotine Dependence unspecified-F17.200
Treatment Plan / Recommendations
Plan: Supportive therapy provided. Psychiatric team will monitor mood and behavior, Performance measures Neuropsychiatric symptoms reviewed, Patient is encouraged to

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participate in activities on the unit
Continue psychotherapy
Patient motivated to verbalized any concerns at any time with the staffs
Will continue to monitor his mood and behavior."
This note was signed by OSM #6, the psychiatric NP (nurse practitioner).

A review of Resident #64's comprehensive care plan dated 7/25/18 and most recently updated 8/16/21 revealed, in part: "Resident #64 is at risk of a change/decline in his mood and/or psychosocial status d/t (due to) continuing ETOH abuse, nicotine dependence, hx of aggressive/intimidating behavior twoard elderly residents, being younger than the general population...Encourage and allow to ventilate feelings...Mental Health Consult."

On 9/15/21 at 1:58 p.m., ASM (administrative staff member) #1, the administrator, and ASM #4, the clinical services specialist, were interviewed. When asked to provide additional information regarding Resident #64's stay at the facility, ASM #4 stated the psychologist has documented the resident likely has PTSD (post-traumatic stress disorder) (4), bipolar disorder and a mood disorder. She stated the resident is resistant to care and support, that he is independent, and he is able to provide his own care. She stated the staff has been working with Resident #64 on medication management and verbal communication rather than aggression.

On 9/15/21 at 3:46 p.m., OSM #6, the psychiatry NP, was interviewed. She stated she has not seen Resident #64 since May 2021. When asked why she has not seen Resident #64 since 5/14/21, OSM #6 stated when the resident does

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not have anything "particular" happening, she does not see him formally. She stated she will sometimes have a conversation in the hallway, but has not had any "billable visits" since 5/14/21. OSM #6 stated Resident #64 refuses all services and medications she offers. When asked if she documented any offers and refusals, she stated she has not. OSM #6 stated the resident leaves the building, and the facility staff has tried to set limits. She stated the resident had an incident in May 2021 that resulted in a contract between the resident and the facility. When asked if Resident #64 is safe to leave the building unsupervised, given his history of falls and seizures, she stated he could be. OSM #6 stated, "It is really difficult to determine his safety." She stated staff has documented that when he returns from his unsupervised time out of the facility, frequently he has dilated pupils and is "clearly altered." OSM #6 stated,"We need to assess him for mental capacity."

On 9/16/21 at 9:21 a.m., OSM #7, the psychologist, was interviewed. When asked about Resident #64, she stated he is sometimes totally alert and oriented, and capable of caring for himself. She stated at other times, he is, in her opinion, under the influence of some type of psychoactive substance. OSM #7 stated, "He turns into a monster." She stated he cannot find his words, and he becomes belligerent and paranoid. When asked why she has not seen Resident #64 since 4/8/21, she stated it is because he will not talk to her. OSM #7 stated the team has offered Resident #64 a medication to treat bipolar disorder, but he has repeatedly refused. She stated she is not certain that Resident #64's is not more of a substance abuse problem than a mental illness. OSM #7 stated, "Is

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it undiagnosed PTSD (post-traumatic stress disorder) (3)? I can't say he is absolutely bipolar."

On 9/16/21 at 9:51 a.m., ASM #1, ASM # 3, director of operations and ASM # 4, clinical service specialist, were informed of these concerns.

On 9/16/21 at 2:09 p.m., a policy regarding PASRRs was requested. ASM #1 stated the facility does not have this policy.

No further information was provided prior to exit.

REFERENCES
(1) "Bipolar disorder (formerly called manic-depressive illness or manic depression) is a mental disorder that causes unusual shifts in mood, energy, activity levels, concentration, and the ability to carry out day-to-day tasks." This information is taken from the website https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) "The epilepsies are a spectrum of brain disorders ranging from severe, life-threatening and disabling, to ones that are much more benign. In epilepsy, the normal pattern of neuronal activity becomes disturbed, causing strange sensations, emotions, and behavior or sometimes convulsions, muscle spasms, and loss of consciousness." This information is taken from the website https://www.ninds.nih.gov/Disorders/All-Disorders/Epilepsy-Information-Page.

(3) "Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous

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F 740	Continued From page 103 event...Those who continue to experience problems may be diagnosed with PTSD. People who have PTSD may feel stressed or frightened, even when they are not in danger." This information is taken from the website https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.	F 740		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility	F 761	1. It is noted that facility staff failed to	10/26/21

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F 761	Continued From page 104 document review, it was determined the facility staff failed to ensure proper labeling and storage of drugs in one of three medication carts observed, medication cart on the Fairview unit. An unlabeled Ventolin inhaler without the box packaging was observed stored, available for resident use in the middle drawer of the Fairview unit. the findings include: Observation was made of the medication cart on the Fairview unit, middle hall on 9/16/2021 at 11:32 a.m. An inhaler, Ventolin HFA (1), was observed sitting in the middle drawer of the medication cart. There was no resident name, no pharmacy label, and nothing documented on the container. There was no empty box for the inhaler in the drawer. An interview was conducted with LPN (licensed practical nurse) #4 on 9/16/2021 at 11:32 a.m. When asked who the inhaler belonged to, LPN #4 stated the resident was no longer there. LPN #4 stated he grabbed it and threw away the box. He stated he didn't know how to discard the medication. An interview was conducted with RN (registered nurse) #4, the assistant director of nursing, on 9/16/2021 at 11:33 a.m. When asked about the process staff follows for discarding medications when a resident is discharged, RN #4 stated the nurse is to put them in the containers in the medication room. The medications go in the box to be sent away to be destroyed. The facility policy, Medication Storage,	F 761	ensure proper labeling and storage of drugs on one of three medication carts. The medication on cart 2 was discarded on 9/16/21 2. Any resident who resides at the facility could be affected if the facility fails to provide proper labeling and storage of drugs. 3. The DON or Designee will educate licensed nursing staff on proper storage and labeling of drugs. 4. DON or designee will audit drug storage and labeling 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 5. Compliance date is 10/26/21.	

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F 761	Continued From page 105 documented in part, "1. (Name of pharmacy) dispenses medication in packaging/containers that meet regulatory requirements. Medications shall be kept and stored in these packages/containers." ASM #1, the administrator, ASM #2, the director of nursing, ASM # 4, the clinical services specialist and ASM #3, the director of operations, were made aware of the above concern on 9/16/2021 at 3:33 p.m. No further information was provided prior to exit. References: (1) Ventolin Inhaler: used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease)This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682145.html	F 761		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident	F 804	1.It is noted facility staff failed to ensure	10/26/21

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F 804	Continued From page 106 interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure food was served at temperatures palatable for meal enjoyment during the lunch meal on 9/15/21. The findings include: On 9/14/21 at 12:12 PM, an interview was conducted with Resident #38. She stated that the food was "an issue." She did not give specifics. However, a complaint being investigated regarding Resident #38, dated 6/3/21, also alleged that the resident had reported that the food was "so bad she won't eat it." A review of facility grievances revealed one dated 12/17/20 from Resident #38 that documented, "Resident reports food is still horrible and has gotten worse...." Resident #38 was admitted to the facility on 11/16/19 with the diagnoses of but not limited to congestive heart failure, rheumatoid arthritis, diabetes, Hodgkin's lymphoma, Meniere's disease, adjustment disorder, anxiety, and depression. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 7/12/21. The resident was coded as being cognitively intact in ability to make daily life decisions. On 9/15/21 a test tray was conducted for the lunch meal. This test was conducted as follows: Temperatures were obtained of the food on the trayline in the kitchen at 11:21 AM by kitchen staff	F 804	food was served at temperatures for meal enjoyment. Resident #38 interviewed on 10/8/21 regarding palpability adjustments made no untoward effects to resident. 2.Any resident who resides in the facility could be affected if the facility does not provide food at temperatures for meal enjoyment. 3.The Dietary manger or designee will educate administrative staff, licensed nurse, C.N.A's, therapy and dietary will be educated on serving food at temperatures palatable for enjoyment. 4.The dietary manager or designee will audit food temperatures 5x a week for 4 weeks and monthly x2. 5.Compliance date is 10/26/21.	

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with a kitchen thermometer, and was observed by this surveyor and OSM #1 (Other Staff Member) the dietary manager. The temperatures were as follows:

Chicken 201.9 degrees
Rice 192.2 degrees
Asparagus 202.1 degrees
Pureed rice 208.7 degrees
Pureed asparagus 203.0 degrees
Pureed chicken 203.7 degrees
Ground chicken 208.4 degrees
Pepper steak 201.3 degrees
Carrots 199.5 degrees
Noodles 195.6 degrees

On 9/15/21 at 12:15 PM a test tray was requested for the last meal cart. The test tray was the last tray on the cart at 12:24 PM and delivered to the unit. The cart was an open style cart, rather than an insulated cart with doors that closed. The cart of trays arrived to the unit at 12:26 PM.

The last resident was not served their tray off the cart until 1:00 PM

On 9/15/21 at 1:00 PM the food temperatures were obtained using a facility thermometer by OSM #1 and OSM #3 (the dietary district manager), as follows:

Chicken 130.1 degrees, a 71.8 degree drop
Rice 122 degrees, a 70.2 degree drop
Asparagus 125 degrees, a 77.1 degree drop
Pureed rice 137.1 degrees, a 71.6 degree drop
Pureed asparagus 132 degrees, a 71 degree drop
Pureed chicken 137.6 degrees, a 66.1 degree drop

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F 804	Continued From page 108 Ground chicken 126.3 degrees, an 82.1 degree drop Pepper steak 127 degrees, a 74.3 degree drop Carrots 124.1 degrees, a 75.4 degree drop Noodles 129 degrees, a 66.6 degree drop Two surveyors, OSM #1 and OSM #3 all taste tested the food. All agreed that the flavor was good but that the food temperature had dropped significantly and was not hot enough for meal enjoyment. The food palatability ranged between room temperature and luke warm at best. A review of the facility policy "Food Production" documented, "Policy: Food will be prepared under sanitary conditions as outlined in the most current FDA Food Code using methods that conserve nutritive value, quality, flavor and appearance....10. Food should be tasted by the cook during and after preparation to ensure palatability....11. Food should be prepared as close to serving time as possible and should be held in a steamtable no more than 30 minutes prior to service...." On 9/16/21 at approximately 3:30 PM, ASM #1 (Administrative Staff Member), the Administrator, and ASM #2, the Director of Nursing was made aware of the findings. No further information was provided by the end of the survey. COMPLAINT DEFICIENCY.	F 804		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		10/26/21

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F 812	Continued From page 109 §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 observation, staff interview, and facility document review, it was determined that the facility staff failed to prepare and serve food in a sanitary manner. During observation of trayline services on 9/15/21, OSM #2 (Other Staff Member), a dietary aide picked up a sandwich off the floor and continued preparing meal trays without changing gloves and washing her hands. The findings include: On 9/15/21 at 11:20 AM, the trayline service was observed in the kitchen. OSM #2 (Other Staff Member), a dietary aide, was at the end of the trayline, adding final items to the trays, i.e. desserts, beverages, etc., before placing on the cart for delivery. During this observation, at 11:56 AM, OSM #2	F 812	1. It is noted that facility staff failed to prepare and serve food in a sanitary manner. OMS#2 was re-educated on preparing and serving food in sanitary manner. 2. Any resident who resides in the facility could be affected if the facility fails to provide and serve food in a sanitary manner. 3. The dietary manger or designees will educate dietary on serving food in a sanitary manner. 4. The dietary manager or designee will audit for sanitary preparation of food 5x a week for 4 weeks and monthly x2 and report findings to QAPI committee. 5. Compliance date is 10/26/21.	

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F 812	Continued From page 110	F 812		

was observed retrieving a sandwich from a nearby refrigerator for a tray. OSM #2 dropped the sandwich on the floor, picked it up off the floor, and placed it on a nearby stainless steel table, away from the food prep area. She then obtained another sandwich, placed it on the resident's tray. She continued with the trayline service of finishing off the trays with final items and carting them; all without changing her gloves and washing her hands after she had picked the sandwich up off the floor.

On 9/15/21 at 1:40 PM, an interview was conducted with OSM #3, the dietary district manager. She stated that by this time, OSM #2 had left for the day, and was part time, so she would not be back the next day. When notified of the above observation, OSM #3 stated that OSM #2 should have taken her gloves off and washed her hands before returning to the trayline.

A review of the facility policy A review of the facility policy "Food Production" documented, "Policy: Food will be prepared under sanitary conditions as outlined in the most current FDA Food Code using methods that conserve nutritive value, quality, flavor and appearance...7. Employees will wear disposable plastic, or vinyl powderless gloves...Gloves must be changed when they become soiled or damaged, or when the employee changes tasks or is working with a different food."

On 9/16/21 at approximately 3:30 PM, ASM #1 (Administrative Staff Member), the Administrator, and ASM #2, the Director of Nursing was made aware of the findings. No further information was provided by the end of the survey.

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F 880	Continued From page 111	F 880		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880		10/26/21

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F 880	Continued From page 112 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to provide care and services in a manner to prevent the spread of infection on two of three hallways on the Fairview Unit, the "warm" hallway , and the combination hallway containing both "warm" and "cold" residents. Two CNAs (certified nursing assistants), CNA #6	F 880	1. It is noted facility staff failed to provide care and services in a manner to prevent the spread of infection. C.N.A #6 and #7 was re-educated on donning proper PPE when entering isolation room and handwashing during meal delivery service. 2. Any resident who residents in the facility could be affected if infection control	

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and CNA #7 were observed distributing meal trays, setting up resident meal trays, and removing meal trays from resident rooms on the warm hallway and the combination hallway of the Fairview Unit during lunch on 9/14/21. They were not wearing gloves or gowns when coming into contact with personal items and linens in the "warm" rooms, were not wearing gloves when handling trays from the "hot" rooms, and were not consistently sanitizing their hands between residents.

The findings include:

On 9/14/21 at 11:15 a.m., an entrance conference was conducted with ASM (administrative staff member) #1, the administrator. When asked if any residents were on isolation, she stated much of the Fairview Unit was an isolation unit. She stated the unit contained three hallways. One hallway was completely "warm," meaning all residents on this hallway were on both droplet (1) and contact precautions (2) because of possible exposure to COVID-19 (3). ASM #1 stated one hallway contained both "warm" and "hot" residents, adding that "hot" residents currently have tested positive for COVID-19. She stated all residents on this hallway are also on both contact and droplet isolation precautions. She stated that the third hallway contained both "warm" and "cold" residents, adding that "cold" residents have not had a known exposure to COVID-19 and are not on isolation precautions. ASM #1 stated that all staff are to wear gown, gloves, mask, and eye protection when they enter any resident's room on the "warm" or "hot" units.

On 9/14/21 at 12:23 p.m., CNA #7 was observed delivering meal trays to room 226, on the "warm"

practices are not followed.
3. The DON or designee Center staff will be educated on infection control practices for the use of PPE and hand hygiene.
4. DON or designee will audit infection control practices 5x a week for 4 weeks and monthly x2.
5. Compliance date is 10/26/21.

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unit. She did not wear a gown or gloves. She set up the meal tray for the resident, and her uniform came into contact with some of the resident's belongings on the overbed table, and with some of the resident's bed linens. She did not wash her hands before she left the room. She picked up a new meal tray and delivered it to room 227, on the "warm" unit. She did not wear a gown or gloves to do so. She sanitized her hands, and picked up another tray and delivered it to room 223, on the "warm unit." She did not wear gown or gloves when she entered room 223.

On 9/14/21 at 12:42 p.m., CNA #7 was observed in room 228D on the "warm" hallway, helping the resident with her meal tray. CNA #7 was not wearing a gown or gloves as she touched the resident's spoon, moved items around on the resident's overbed table. CNA #7's uniform was observed coming in contact with the resident's bed linens. Without washing her hands, CNA #7 put on gloves, picked up a knife, and cut meat on the resident's tray. CNA #7 removed her gloves, but did not wash her hands, and left the room to go to the kitchen. CNA #7 returned from the kitchen with an item of food, and, without putting on a gown or gloves, placed the item of food on the resident's overbed table. She left the room holding two plate covers with her bare hands, and put the plate covers on the tray collection cart in the hallway. Without washing her hands, she went to room 223, on the "warm" unit and put on a pair of gloves. She touched items on an overbed table, and picked up a meal tray and placed the tray on the hallway collection cart.

On 9/14/21 at 12:57 p.m., CNA #6 was observed not wearing gloves, standing in the hallway on the "warm" side of the barrier to the "hot" unit. A staff

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member on the "hot" unit handed CNA #6 a tray with empty food containers and half-eaten food. Without putting on gloves, CNA #6 put the tray on the tray collection cart on the "warm" hallway. Without sanitizing her hands or putting on a gown, she walked into room 230, on the "warm" unit. She put on gloves, and assisted the resident with wiping spilled food from his clothing and mouth. She removed the gloves and sanitized her hands.

On 9/14/21 at 2:02 p.m., CNA #7 was interviewed. When asked why a resident would be placed on the "warm" unit, she stated residents are placed there because they could have been exposed to COVID-19, and may have COVID-19 but have not yet tested positive for it. When asked what PPE (personal protection equipment) is required for her to enter a resident's room on the "warm" unit, CNS #7 stated she needs goggles, gloves, and a gown. She stated she also needs gloves. She stated the PPE is to be worn in order to keep the staff from potentially carrying the virus from resident to resident. When asked if she remembered wearing gown and gloves during distribution and collection of lunch trays earlier in the day, CNA #7 stated, "We only wear the gown when we are doing personal care." When asked what she should wear if she is brushing up against bed linens or handling resident belongings, CNA #7 stated, "Possibly a gown." She added: "We are supposed to sanitize our hands between residents."

On 9/14/21 at 2:15 p.m., CNA # 6 was interviewed. She stated the "warm" zone is for new admissions, and for residents who frequently leave the facility for some reason. When asked

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what PPE is required during lunch tray distribution and collection on the "warm" unit, CNA #6 stated, "We don't wear a gown, but we don't get close to the resident." When asked if she was aware that she had come into contact with a resident's personal belongings during lunch tray distribution, she stated she was not. When asked about not wearing gloves when handling the tray passed to her from the "hot" zone, CNA #6 stated, "I should have worn gloves then. But we have been told we are not allowed to wear gloves at all in the hallways." She stated she knows she should wear gloves when she removes trays from the rooms.

On 9/16/21 at 11:41 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked what PPE should be worn by staff delivering or collecting meal trays on the warm unit, he stated staff should wear, a mask, eye protection, gowns and gloves. ASM #2 stated the tray is considered clean going in, and dirty coming out. He stated the staff should wear gloves when removing the trays from the rooms. He stated if staff come into contact with any resident linens or belongings during the tray process, the staff members should definitely wear a gown and gloves. He stated the staff should sanitize their hands between residents.

A review of the facility policy, "Contact Precautions," revealed, in part: "Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, spread by direct or indirect contact with the resident or the resident's environment. In addition to Standard Precautions, use Contact Precautions to prevent nosocomial spread of organisms that can be transmitted by direct resident contact (hand or skin-to-skin

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contact that occurs when performing resident care) or by indirect contact (touching) with environmental surfaces or contaminated resident care equipment...Procedures for Contact Precautions:
Hand Washing/Hand Antisepsis
1. MDROs are transmitted primarily by contaminated hands of staff. The single most effective means of reducing the potential for MDRO transmission is hand antisepsis before and after contact with residents, including after glove removal.
2. Washing hands can accomplish hand antisepsis with an antimicrobial soap and water or by using a waterless alcohol-based hand antiseptic.
Glove Use for Contact Precautions
1. In addition to wearing gloves as outlined under Standard Precautions, clean, nonsterile gloves are worn when providing direct care (changing clothing, toileting, bathing, dressing changes, etc.) to residents on Contact Precautions.
2. Wear gloves whenever touching the resident's intact skin or surfaces and articles near the resident (e.g., medical equipment, bed rails). Don gloves upon entry into the room or cubicle.
3. Gloves should also be worn when handling items potentially contaminated by MDROs. This may
Include items such as bedside tables, over-bed tables, bed rails, bathroom fixtures, television and bed controls, suction, and oxygen tubing.
4. During providing care for residents, gloves will be changed after having contact with infective material that may contain high concentrations of microorganisms (fecal material or wound drainage).
5. Wearing gloves is not a substitute for hand antisepsis. Gloves will be removed and discarded

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before leaving the resident's room, hands will be washed with soap, and water or a waterless hand antiseptic will be used.
6. After glove removal and hand hygiene, staff should ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room to avoid transfer of microorganisms to other residents or environments.
Gown Use for Contact Precautions
1. Don gown upon entry into the room or cubicle. Remove gown and observe hand hygiene before leaving the resident care environment.
2. After gown removal, ensure that clothing and skin do not contact potentially contaminated environmental surfaces that could result in the possible transfer of microorganism to other residents or environmental surfaces.
3. A clean, nonsterile gown with long sleeves will be worn if direct care (bathing, lifting) will be provided or when solid contact with secretions/excretions (incontinence care, linen changes) is anticipated. When such contact is anticipated, the gown should be put on before entering the room or approaching the resident.
4. Gowns should also be worn when body contact with environmental surfaces and items in the room that may be contaminated is anticipated. Especially if the resident is incontinent of urine or stool or has diarrhea, an ileostomy, a colostomy, or wound drainage that cannot be contained by a dressing."

On 9/16/21 at 3:33 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, ASM #3, the director of operations, and ASM #4, the clinical services specialist, were informed of these concerns.

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No further information was provided prior to exit.

REFERENCES

(1) "Droplet Precautions are used to prevent the spread of pathogens that are passed through respiratory secretions and do not survive for long in transit. These droplets are relatively large particles that cannot travel through the air very far. They are transmitted through coughing, sneezing, and talking." This information is taken from the website https://www.cdc.gov/infectioncontrol/pdf/strive/PPE102-508.pdf.

(2) "Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment...Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning PPE upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination." This information is taken from the website https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html.

(3) "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named

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F 880	Continued From page 120 SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments	F 880		